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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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Leaders at the Swearing In Ceremony For Dr. Koomen

Governor Dan K. Moore spoke at the Swearing In Ceremony for Jacob Koomen, M.D., M.P.H., as the new Acting State Health Director took office. Dr. Koomen takes up North Carolina's public health leadership as Dr. J. W. R. Norton relinquishes that post after serving a term of seventeen and a half years. Governor Moore commended Dr. Norton's achievements and bespoke support for the new leadership. Dr. Lenox D. Baker of Durham, president of the State Board of Health, presided. Shown in the picture, from the left, are: Dr. Koomen, Governor Moore, Dr. Norton and Associate Supreme Court Justice Susie Sharp, who administered the Oath of Office.



**Appreciation
for
A Fine Record**

**Confidence
in Leadership
for the Future**

Dr. J. W. R. Norton, North Carolina's State Health Director for the past seventeen and a half years, resigned this position effective January 1, 1966. Health reasons dictated a less strenuous pace. The State Board of Health accepted Dr. Norton's resignation with expressions of appreciation for his outstanding service to public health.

As Acting State Health Director, the State Board elected Dr. Jacob Koomen, who has served as Assistant State Health Director since October 1, 1961, and has been with the State Board since August 1, 1954. Dr. W. Burns Jones, Jr., Director of the Local Health Division, who has been with the Board since November 1, 1962, was named Acting Assistant State Health Director. Both were elected to finish out the remaining year and a half of Dr. Norton's four-year term. Governor Dan Moore approved these selections of the Board.

Dr. Koomen was sworn in at high noon, January 4 with Governor Dan K. Moore and other dignitaries participating. Supreme Court Justice Susie Sharp administered the oath of office. Dr. Lenox Baker, president of the Board, presided. Dr. Norton continues with the State Board as Director of the Local Health Division.

Dr. Koomen and Dr. Jones are well known in public health work and North Carolina is fortunate in having such well prepared and capable men to assume these responsibilities.

Jacob Koomen, M.D., M.P.H., Becomes North Carolina's Acting State Health Director

The John H. Hamilton Auditorium in the Laboratory Building of the State Board of Health was the scene of a most colorful and memorable occasion on Tuesday, January 4, 1966, at high noon. Governor Dan K. Moore and State Health Board President, Lenox D. Baker, M.D., were among the dignitaries who witnessed the Swearing-In Ceremony of Jacob Koomen, M.D., as North Carolina's Acting State Health Director. Justice Susie Sharp of the N. C. Supreme Court administered the Oath of office.

Governor Moore expressed the appreciation of the State for the long and commendable service of J. W. R. Norton, M.D., who relinquished that position after nearly 18 years. He expressed satisfaction that the State had in Dr. Koomen a successor who not only knew North Carolina but was outstanding and experienced in the concerns of public health. Dr. Baker presided and commented on the earnest purpose of public health in traffic safety measures.

Representatives of many State agencies and presidents of a number of voluntary health agencies were among the crowd in the over-flowing auditorium.

Dr. Koomen

Dr. Jones

Dr. Baker

Justice Sharp





Governor Dan K. Moore gives Dr. Koomen assurance of his support in health concerns.

Newspapers Laud Dr. Norton's Record and Commend the New Leadership

CHANGING THE GUARD

North Carolina has lost a fine public health administrator with the retirement of Dr. J. W. R. Norton as State health director. He has given stable leadership to the State Board of Health staff during the past 17 years. And he rendered especially high service in dealing with this State's worst polio epidemic during his first several months in his post.

He has earned numerous honors in his field, including the presidency of the American Public Health Association. And he, in turn, has honored his State with his years of faithful public service.

While Dr. Norton will be missed, North Carolina is fortunate in his successor, Dr. Jacob Koomen, an able executive and physician and a first-class gentleman. He is more than equal to the appointment to fill out Dr. Norton's term. This State's public health system would be fortunate to get a man of Dr. Koomen's caliber from anywhere; it has been generously blessed to have him here since 1954.

It is a wonder indeed that he did not accept a more inviting challenge and higher remuneration outside of North Carolina before now. It would have been difficult for the State Board of Health and Governor Moore to find a better man for the job of State health director.

News and Observer

The Health Bulletin

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Outstanding Record

The slightly hackneyed phrase, "local boy makes good," can be taken out, dusted off and used without fear of contradiction in reference to Dr. J. W. R. Norton, whose resignation as North Carolina Health Director was announced last week.

Dr. Roy, as he is familiarly known to his Scotland County home folks, steps down after almost 18 years in harness, and with him goes a most distinguished career of public service.

Few Scotland Countians have compiled a more outstanding record in their chosen fields than Dr. Norton, and it is even more unusual in that he first tried his hand in the field of education and later law before embarking on a medical career.

After graduating with an A.B. degree from Trinity College (now Duke), he was principal and coach at Lumberton High School in the early '20's and then earned a law degree at Trinity.

Another year of teaching and coaching, this time at Sneads Grove school, followed before the young man entered medical school at the University of North Carolina.

He earned his M.D. at Vanderbilt and practiced at Henry Ford Hospital in Detroit and later in Fort Smith, Arkansas, before returning to his home state as Superintendent of Health at Rocky Mount.

Prior to World War II Dr. Norton served with the North Carolina Board of Health as Assistant Director of County Health Work and Assistant Director in the Division of Preventive Medicine, and also was Professor of Public Health Administration at the University of North Carolina.

After a distinguished record with the Army in North Africa, Italy and England during the World War II, joined the Tennessee Valley Authority as a Staff Officer. He became North Carolina State Health Director in 1948.

Dr. Norton's tenure as Health Director was distinguished in many ways. His prompt and decisive action in combating the state's worst polio epidemic in 1948 brought this comment from Gov. Dan K. Moore:

"The citizens of North Carolina, if for no other reason, owe Dr. Norton a tremendous debt of gratitude for his prompt and zealous actions in dealing with the 1948 polio epidemic, which was the worst in the state's history."

Dr. Lenox Baker, president of the State Board of Health, paid Dr. Norton this tribute, "I think North Carolina has lost the outstanding health director in the Nation."

At the age of 67, we would say Dr. Roy is entitled to pass the responsibilities of his office to younger shoulders. We wish him well and hope future plans call for even closer ties with the "home folks."

Laurinburg Exchange

You have furnished such outstanding and devoted direction to health affairs of North Carolina during your directorship of that important responsibility that it seemed you'd just go on forever as the indispensable man.

You have written your name high in service of this state, for which all of your many friends, of whom I'm glad to be included, are proud.

Holt McPherson, Editor
The High Point Enterprise

Health Program Expansion Attributed to Norton Leadership

Dr. Norton's decision to step down is a relatively rare occurrence on the high political or semi-political level. But recent cardiographs have shown that he has some slight irregularities. In his own words, "I would have recommended it to anyone else. I'm taking my own advice. You know, they say doctors never follow their own advice." He also recognizes, at 67, the exactions and requirements of the position which he has been filling: "The time has come to pass the burdens and the privileges . . . to one with the youthfulness, flexibility, energy and enthusiasm now needed more than ever in this job."

Dr. Norton, coming to North Carolina during the 1948 polio epidemic, stepped into the efforts to combat it with vigor and effectiveness. He has served long enough to see polio practically eliminated and North Carolina's tuberculosis death toll cut from around 4,000 to less than 200 annually.

The state's health program, its personnel and budget, has deepened and broadened; and in large measure this expansion to meet new needs can be attributed to his vision and leadership.

Greensboro Daily News

Service Held In Grateful Remembrance

That Dr. J. W. R. Norton has found it advisable, because of his years and the state of his own health, to resign as state health director is cause for sincere regret. He has given to the state able and dedicated service; he has led a consistent effort to strengthen the public health program; and he has been a willing collaborator in numerous projects to improve the health of the people of the state.

All save the very young will not forget the circumstances prevalent when Dr. Norton assumed direction of the State Department of Health. North Carolina was in the summer of 1948 in the grip of particularly virulent epidemic of poliomyelitis, the worst in Tarheel history. Both Governor Moore and Dr. Lenox Baker, president of the State Board of Health, properly recalled Dr. Norton's prompt and vigorous handling of the critical problem in their appreciative comments on his service. And multitudes of North Carolinians hold that service in grateful remembrance.

If Dr. Norton's subsequent service over the past 17 years was less spectacular, it was nonetheless significant. An achievement of continuing importance was the rewriting of the state's health laws, in which he took the lead, by the 1957 General Assembly. This, perhaps, he regards as the outstanding accomplishment of his tenure as health director.

For the people, Dr. Norton's alertness to progress in medical science and his translation of this progress into the public health program stands out. And to those who have had an opportunity to observe at fairly close range, Dr. Norton's practice of giving to subordinates in the Health Department responsibility and opportunity both to learn the overall health needs and program and to show initiative in meeting health problems has been impressive. That this generous practice has paid off in substantial dividends to the state is evident in the presence on the Health Department staff of a man well qualified to carry on the work of the health director, Dr. Jacob Koomen, who will complete Dr. Norton's term. And happily Dr. Norton will continue to serve as head of the Local Health Division, a post in which the duties and responsibilities are less demanding.

Durham Morning Herald

. . . From One Top-flight Man to Another

North Carolina is fortunate in being able to change its top public health command from one top-flight man to another top-flight man.

When Dr. J. W. R. Norton resigned yesterday as State health director, he closed a distinguished career of more than 30 years of public health work in this State, on both the county and state level. For all that he did during those years to keep North Carolina abreast of developments in the public health field, the people of this State can be grateful.

And, the people can be grateful that a man of Dr. Jacob Koomen's stature was available to step into the public health directorship. Dr. Koomen, who has been assistant director for several years, has been named acting director. He undoubtedly will do the kind of job which will mean that he should

be named director at the end of the remaining year and a half of Dr. Norton's unexpired term.

The job of director of public health is always a very important one for all the people of the State. It is the kind of never-ending proposition which always demands the most skilled people.

There will be an additional reason during the years immediately ahead as the State moves into the various federal health programs, led by Medicare. Although the administration of Medicare won't necessarily fall completely into the lap of the State health director, he most surely will have a major role in seeing to it that the program is carried out to best advantage in North Carolina.

Dr. Koomen is completely qualified as a public health expert having all the medical and other scientific training needed for the post. In addition, he has been in public health work in North Carolina for a number of years, and is completely familiar with the details of any problems peculiar to this State. This specialized knowledge makes him especially well fitted for the State's top health job.

In addition to being so well qualified professionally, Dr. Koomen is excellent in his handling of public relations. He knows how to get along with people, and is able to get across to them the message of public health. This ability would be valuable at any time, but will be especially so during the years when North Carolina is moving more and more into the fields of Medicare and other federal areas.

Dr. Koomen knows the value of public support for any matter of importance. He can be counted on to continue to take to all the people the story of North Carolina medical and public health needs at a time when public support and understanding will be especially needed.

Raleigh Times

North Carolina's New Leader in Public Health Finds Strength in His Fine Family



In the picture, from the left — seated: Mrs. John F. Chapin, Mrs. Koomen's mother; Marcia Anne Koomen, Senior at Broughton High School, and Mrs. Koomen (Ruth). Standing: Neil C. Koo-



men, a fourth grader at Fred Olds School; Nancy Carol Koomen a seventh grader at LeRoy Martin School, Dr. Jacob Koomen, John C. (Scotty) Koomen, a Junior at UNC, Chapel Hill.

Commendations of Dr. Norton Come From Near and Far

Editor's Note: At our request, Dr. Norton permitted the Editor to read the scores and scores of letters received from over the nation. On this and the following pages excerpts from a few of these are quoted. Lack of space made it impossible to refer to more than a small number from among the flood that came to express appreciation for a job well done and good wishes for a useful and effective service in the years ahead.

Lenox D. Baker, M.D., President
State Board of Health
Duke Hospital
Durham, North Carolina
Dear Doctor Baker:

As a long-time friend and admirer of Doctor J. W. R. Norton, I should like to tell you how much we have appreciated his help and leadership in the American Public Health Association; and how much we know North Carolina has benefitted by his leadership in your state. Although we regret seeing him leave his position as Director of the State Department of Health, we are happy to learn that he is going to continue with the Department in another post.

We should also like to congratulate you on benefitting by Doctor Norton's foresight in having recruited and trained his successor, Doctor Jacob Koomen. Doctor Koomen will continue and expand imaginative and effective public health leadership in North Carolina. The continuity which your Board has provided in support and leadership for public health in your state is to be highly commended.

Sincerely yours,
Berwyn F. Mattison, M.D.
Executive Director
The American Public Health
Association

As an humble citizen of North Carolina, I want you to know how much I personally appreciate the high plateau on which you have operated and the many good things you have done for our people. You deserve many years of commendation for you have indeed done an excellent job with a difficult situation.

George D. Colclough, Burlington
Manager, Chamber of Commerce

Dr. Norton, you have rendered a great service and have won the admiration of the public health workers and the public at large. To have known you through all of these 29 years has been wonderful. It has only made the early impressions you made on me grow into love and admiration and esteem.

W. Raleigh Parker, M.D., Director
Northampton County Health
Department

It has been a pleasure for me to work with you through the years in improving health services for mothers and children in North Carolina.

Madeleine E. Morcy, M.D.
Regional Medical Director
Children's Bureau

I have appreciated my association with you, especially back in 1949, just after you came to North Carolina and I was Chairman of the House Health Committee. I congratulate you on your fine record in office.

Roy A. Taylor
Member of U. S. Congress
From the 11th District

The people of North Carolina will miss you and your contributions more than they now realize.

John R. Pate, M.D.
Department of Public Health
Washington, D. C.

I want to say, and very emphatically, that I will miss you very much among the ranks of State Health Officers. You have been a stalwart in the group for a long time. I am sure that all the other State Health Officers will miss you too.

Wilson T. Sowder, M.D.
State Health Officer
Florida

I want to express my deep appreciation for the years of notable leadership and service you have given to the health and welfare of North Carolina.

Horace R. Kornegay
U. S. Congressman
From the 6th District

You have certainly been one of the country's outstanding public health administrators and guides. I have personally learned much from you.

The nation owes you a debt of gratitude for what you have done to improve public health practice in your home state and throughout this country.

C. L. Wilbar, Jr., M.D.
Commonwealth of Pennsylvania

You have certainly been one of the anchor men in public health and have given all us newcomers sage words of advice that have enabled us to carry on for a short time at least. I am particularly grateful for your participation and interest in the Environmental Health activities of Association of State and Territorial Health Officers and, especially, for your service on the Occupational Health Subcommittee.

Richard H. Wilcox, M.D.
State Health Officer
State of Oregon

We in the state health ranks are most grateful for all you have done in achieving distinction not only for yourself and the State of North Carolina, but public health in general.

Franklin D. Yoder, M.D.
Director of Public Health
State of Illinois

My very best wishes go with you in your new position. I am sure you will continue to exercise responsible public health leadership as you have for the many years in the past.

G. D. Carlyle Thompson, M.D.
Director of Public Health
Utah State Department of Health

Over these many years we have appreciated your statesmanship and your wise counsel and I know we have your full assurance that we can call upon you for "special assignments" as the need develops in the years ahead.

Albert E. Heustis, M.D.
Secretary-Treasurer
The Association of State and
Territorial Health Officers

Since getting acquainted with you during our military days in 1944-45 it has been a real pleasure to work with you on a wide variety of problems in the field of public health. I know that under your leadership tremendous advances have been made in North Carolina which have had implications for all of the other states.

Franklin M. Foote, M.D.
Commissioner
State Department of Health
State of Connecticut

Honored Even "In His Own State"

I personally want to thank you for the excellent work during your tenure in office as State Health Officer. North Carolina has maintained its space on the top rung of the ladder of progress during your tenure, and I am sure that there will be many times that your absence will be felt. I personally thank you for the job well done. It has been a pleasure for me to work with you from time to time, and I'm happy that I have had the opportunity of knowing you during these trying days.

John R. Kernodle, M.D., Burlington
A Past President of the
Medical Society of the State of
North Carolina

Along with your many friends throughout the Nation, I wish to express my sincere gratitude to you for the magnificent job that you have done for better health in North Carolina. Our state has been most fortunate to have a man of your professional caliber, capability and dedication and the great results that you have achieved are a monument to your accomplishments. I am particularly grateful to you for the high emphasis that you have always placed on traffic accident prevention.

The prominence and recognition that North Carolina enjoys on a national scene today are directly attributed to the efforts of outstanding governmental leaders such as you.

Charles A. Speed, Commander
State Highway Patrol

. . . and In His Home Town

I want you to know that I and many other North Carolinians deeply appreciate the fine job you have done for a number of years as head of our State Health Department. Your fine leadership has meant much to the good health of North Carolinians.

Edwin Pate
Laurinburg

Yours has been a long and rewarding career in Public Health in North Carolina, and I know that you can look back on it with a real sense of personal satisfaction and accomplishment. I want to extend to you my warmest personal congratulations for a successful career and also that of each member of the staff of my three health departments.

The Nash County Board of Health was delighted to draw up a resolution in recognition of your long and successful career in public health. There was a personal feeling among the Board since part of your career was in Rocky Mount and you resided in Nash County.

John S. Chamblee, M.D.
Nash County Health Director

For your great, useful and courageous service I shall ever be grateful and such must be the feeling of the citizenship of our State.

Charles B. Deane, Attorney
Rockingham

You have done a wonderful job and we're all very grateful.

Tom Davis, Chief of Police
The Raleigh Police Department

May I join your many Wachovia friends in acknowledging to you a job well done for the many years of service as Director of our State Board of Health. Congratulations again on a job well done.

S. L. Gulledge, Jr., Raleigh
Vice President
Wachovia Bank & Trust Co.

All of us who watched the developments under your responsibility take pride in what you have accomplished and congratulate you and your associates in the admirable and constructive manner in which you have administered a complex and difficult program for North Carolina. You should have very real satisfaction in your accomplishments.

W. Reece Berryhill, M.D.
Professor of Medicine and Dean
Emeritus, School of Medicine
University of North Carolina

May I take this opportunity to join your host of friends in a chorus of praise of your wonderful leadership of the Department of Public Health in North Carolina over the past years—it has been superb.

Harold D. Meyer, Chapel Hill
Curriculum in Recreation
Administration
University of North Carolina

It is going to seem impossible for North Carolina to get along without you. Your successor is a great one, also a tribute to you, but I just want you to know that I am like many, many other Tar Heels who have a special place in their heart for you.

Voit Gilmore, Southern Pines
Senator, 18th District

You have certainly rendered outstanding service to the people of North Carolina and I assure you that it has been a pleasure to have been associated with you to some degree for a number of years.

F. S. Royster, Chairman
State Personnel Board

I want to tell you that you have rendered outstanding public service—that I enjoyed greatly my association—and that I hope all goes well for you.

Terry Sanford, Fayetteville

You have had a most successful and distinguished career in Public Health and have received many well deserved honors. Your outstanding reputation in Public Health has given you, and will continue to give you great personal satisfaction. It will always be a source of pride to your loved ones and friends. The State of North Carolina and all of its citizens are justly proud of you and your wonderful contribution to Public Health in our state and nation.

You are very fortunate to have Dr. Koomen, a young man of character, experience, and notable attainment, succeed you as State Health Director. You will no doubt receive much pleasure in watching him carry forward the torch of progress that you have placed in his hands.

E. R. Hardin, Lumberton
Robeson County Health Director

Congratulations on another wise decision! After your long and hard and highly successful career, you certainly deserve and need to get out from under the high pressure.

Hugh A. Thompson, M.D., Raleigh

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James F. Donnelly, M.D.	<i>Director, Personal Health Division</i>

I want to congratulate you on the great service that you have rendered the State and it is not only a matter of permanent official recording and deep appreciation but also appreciation by those who appreciate great leadership.

W. S. Rankin, M.D., Charlotte
Consultant, The Duke Endowment
and one of the first State Health
Directors

I just want to add a word of praise for the good administration you have so long given to the Department of Health in North Carolina, and I read with interest your admonition to yourself about the rigors of doctoring and not following advice. It occurs to me to say that you have been inordinately unselfish in remaining at the post this long, because while I know less than some about the rigors of private medical practice as opposed to the kind of job you have had as a doctor, I would put yours as a more arduous task.

Chas. B. Wade, Jr., Winston-Salem
Vice President
R. J. Reynolds Tobacco Company

The Consolidated Board of Health at its regular meeting on December 8 adopted a resolution expressing its regret on your retirement as State Health Director. The Board wishes to express its appreciation of your many important contributions to the health of the people of this State and this community. I, too, would like to join our Board in this resolution.

C. B. Davis, M.D.
Health Director, New Hanover
County and City of Wilmington

At the special request of the Executive Faculty and on behalf of the entire faculty and staff of the School, I wish to express our grateful appreciation for your close working relationship with us over the years in your role as State Health Director. We do not feel, however, that our association is ending at this point; quite to the contrary, we look forward to calling upon you more frequently in the future for guidance in the many developing programs on the State, national, and international levels.

W. Fred Mayes, M.D., M.P.H.
Dean, School of Public Health
University of North Carolina

As you step down from the position of State Health Officer, I want to commend you for your many years of distinguished service to the State of North Carolina and all its people. We have been blessed with your capable leadership in public health service. I know that you will continue to serve the State well in your new capacity, and we are fortunate to have your wise counsel available in the days ahead.

E. L. Rankin, Jr., Director
Department of Administration
State of North Carolina

This note is merely to add my appreciation for your many years of outstanding service to the people of North Carolina as state health officer and to wish all sorts of nice things for you and Mrs. Norton in the months ahead.

Henry T. Clark, Jr., M.D., Chapel Hill

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I feel that your years of service as State Health Director have been, in spite of many obstacles and difficulties, very productive in terms of progress in public health in North Carolina. Your leadership and philosophy have proven to be an inspiration for public health workers both in this state and throughout the nation.

Benjamin M. Drake, M.D.

Gaston County Health Director
and Acting President, N. C.

Conference of Health Directors

I am one of those many North Carolinians who think the state has had a perfectly splendid health director for these past several years and in addition to a deep admiration for your professional talents and services, I have really enjoyed the opportunity of knowing you.

John Harden, Greensboro

The news of your retirement to less demanding responsibility is a reminder of the significant progress in public health in North Carolina under your direction. I know that the profession is mindful of the fine relationships you have fostered through the years within the profession and in the interest of all of medicine.

Wide recognition of your talents attests to the caliber of your leadership. I count it a privilege to have been a spectator since medical school days and, in a small way, to have been a participant.

John S. Rhodes, M.D., Raleigh
Past President, Medical Society
of the State of North Carolina

Your outstanding leadership since you became the State Health Director in 1948 has consistently kept the North Carolina State Board of Health as one of the leading state health departments in the entire nation. Your contributions to the people of North Carolina have been many and great. Those who have worked as members of your Department, as well as the people of the entire state whom you have served so well, owe you a debt of gratitude that can never be repaid.

Fred T. Foard, M.D.



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MRS. DAN K. MOORE VISITS STATE BOARD OF HEALTH

Evidencing a keen interest in the many and varied programs carried on by the State Board of Health, Mrs. Dan K. Moore toured several areas one afternoon recently. Here Mrs. Moore is shown at the start of the tour as Dr. Jacob Koomen, Acting State Health Director, gives her a pre-view of the areas and activities she will visit. Pictures of a few of the other places visited are shown on other pages of this issue.



Elizabeth S. Holley

New Chief Named in Public Health Nursing

Elizabeth S. Holley became chief of the Public Health Nursing Section of the North Carolina State Board of Health on February 1, 1966.

Miss Holley was associate professor in the Department of Public Health Nursing, School of Public Health, University of North Carolina, a position she has held since 1959. She is a graduate of the Johns Hopkins Hospital School of Nursing, received her A.B. degree from the University of South Carolina and Master's degree at Columbia University. She is immediate past president of Southern Branch, American Public Health Association, and has recently been elected for a three-year term on the Governing Council of the American Public Health Association. She also serves on two APHA committees, the Committee on Affiliated Associations and Regional Branches and the Committee on Racial Integration in Health Services.

Health News Notes

By late in February the selection of contractors to pay doctor's bills under the Medicare program had been made in all but three areas of the United States. These three yet remaining selections to be made were Virgin Islands, Guam and American Samoa. Blue Shield plans will serve 59 per cent of the nation's Medicare beneficiaries. Insurance companies will serve nearly 40 percent and the independent insurer 1 percent.

The fact that 1,000,000 students now in high school will eventually die of lung cancer due to smoking is dramatized in the 16mm film, *SMOKE, ANY-ONE?* Produced for junior and senior high schools, the 10-minute, color motion picture combines live action and animation. It is available for free use from the Film Library of the State Board of Health.

E. B. Crawford, former Executive Vice-President, was elected President of Hospital Saving Association, Chapel Hill, at a meeting of the Board of Trustees in February. Joseph C. Eagles of Wilson, former President, was elected Chairman of the Board of Trustees. Dr. V. K. Hart of Charlotte was elected Vice-Chairman and C. D. Ward of Greenville, Secretary.

Marshall I. Pickens has stepped down as Executive Director of the Hospital and Child Care sections of The Duke Endowment and James R. Felts, Jr., his assistant, has been named to succeed him. Mr. Billy G. McCall has been named Assistant Executive Director. The announcement was made in February by Thomas L. Perkins, Chairman of the Trustees.

BIRTHS in North Carolina declined 7½% in 1965. P.H.S.S. estimates 98,000 resident births occurred in North Carolina in 1965. (down over 7,000 from 1964)

The past year was the first year the State had less than 100,000 annual births since the end of World War II (1945 with 87,401 births was last previous year under 100,000).

Total births and the crude birth rate have been declining generally in North Carolina and nationally since 1957. In the eight year period from 1957-1964, North Carolina has averaged declines in total births at one percent per year. In the three year period 1962, 1963, 1964, the decline in State Births averaged 1¾% per year.

Last year's decrease of 7½% in total births is one of the largest ever recorded in North Carolina. Only one other decline comes anywhere near it; the annual drop of 7.4% recorded in 1922. The 1922 decline, however, followed a two year 10 percent annual increase in births. The decline in 1922 was an expected adjustment to the large birth increase which followed World War I.

The 1965 decrease is most significant

because it follows several years of declining births. Last year's big drop in total births brought the State's crude birth rate to an all time low of 20.4 births per 1000 population. This is 8½% lower than 1964. In 1964 the crude birth rate was 22.3, the lowest rate ever recorded before 1965.

Notwithstanding the significant decline in births, North Carolina need not fear a decrease in total population. There are still more than twice as many births as deaths in the state each year. This natural increase is more than enough to offset the net migration loss experienced by North Carolina and many other Southern States.

When all reports are in, P.H.S.S. expects about 98,000 births and 41,500 deaths in North Carolina in 1965. This will give the state a natural increase of over 56,000.

North Carolina's estimated birth rate of 20.4 births per 1000 population and a death rate of 8.6 deaths per 1000 give the state an annual natural increase (before migration) of about 1.2% per year.

The 1965 national vital rates have been estimated at 19.9 births per 1000 population and 9.1 deaths per 1000.

Traditionally, North Carolina's birth rate has been above the national average and its death rate below that of the Nation. This is primarily a reflection of the state's generally younger population. North Carolina's proportion of young people is above the national average and its proportion of older people is below the U. S. average.

During the past several years the make-up of the state's population has moved closer to the national average and our birth and death rates have become more nearly representative of the U. S. rates.

1965 Saw One of the Largest Losses in Birth Rate

From the Mail

My dear Mr. Preston:

I heard your talk on "colds" on the radio.

It occurs to me that the United States is very far in arrears of Japan on the control of colds; and that Americans should be started on a suitable propaganda campaign. Since being in Japan, I must say I am very shocked to have an intelligent person appear in public or a group, saying: "I am having a cold", and that is that.

In Japan, the first thing I noticed was people on bicycles, on the street, in cars, on trains, on buses . . . with white masks on! Inquiring, I found it against the law to appear in public with a cold, **without** a mask. And, the law was so rigidly enforced that even our guide who did not have a cold, but an allergy, wore a mask to avoid arrest!

When you consider the loss of work hours, the human discomfort, and the long side effects of colds, why in the world do we not take **active** steps to reduce their appearance?

P. S. Why not bestir North Carolina to take a lead in something?

Please accept my thanks (and honest to goodness gratitude) for the "Health Bulletin" these several years. I do like to keep up with medical science, nursing and health tips. I read the bulletin from "cover to cover."

Mrs. R. L. Beckham
1122 Caldwell St.
Statesville, N. C.

I have access to the local school's copy of THE HEALTH BULLETIN. It is so worthwhile. Every adult citizen should read it.

Mrs. J. K. Bell
P. O. Box 433
Dobson, N. C.

The Three Travelers

An ancient legend "tells about three travelers, a long time ago, coming to a walled city in the East. When they got there it was after dark, the gates were closed, and they could not get into the city. One of these travelers liked alcohol, another smoked opium, and the third one liked hashish which we know as marihuana. So they talked it over and decided what they were going to do. The man who did the drinking said 'I'm going to batter the gate down.' The man who smoked the opium said, 'No, I think I'll just sleep until morning.' The third who was using the hashish said, 'I'll slip through the keyhole.'"

*Armstrong, John D. 1966. Drug dependence of alcohol type. American J. Hosp. Pharmacy, 22:130-153. Dr. Armstrong credits the World Health Organization for the story.

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Vol. 81 February, 1966 No. 2

Visiting Nurse Accreditation

The nation's first accrediting program for nursing services went into effect January, 1966, under a program cosponsored by the National League for Nursing and the American Public Health Association. The program offered League accreditation to visiting nurse services and the nursing services of health departments.

The program will focus on protecting and improving the quality of home nursing services which are expanding rapidly across the nation. These are ex-

pected to grow at an even more accelerated rate as communities extend present home nursing programs and develop new ones to provide care for beneficiaries of Medicare.

Hildebran, N. C.

Dear Sirs:

The Health Bulletin has been coming to our home for more years than I can remember, by it we have been profited and informed.

We wanted you to know we are extremely grateful for your kindness.

Sincerely,
George Cook

MRS. DAN K. MOORE VISITS THE DENTAL HEALTH DIVISION

As one of the places visited on her afternoon tour of the State Board of Health, Mrs. Dan K. Moore is shown in the office of Dr. E. A. Pearson, Director of the Dental Health Division. Dr. Pearson told Mrs. Moore of the work of the public health dentists in the schools throughout the State and of the progress of the fluoridation program of public water supplies.



Medicare What It Means to Providers of Services and Physicians

by

James W. Murray

Atlanta, Ga.

**Regional Assistant Commissioner
Social Security Administration**

*Address delivered at Annual Meeting of
N. C. Health Council.*

It is a pleasure to have this opportunity to attend your sixteenth annual meeting and discuss Medicare. We in the Social Security Administration want to talk with as many groups as we can, especially those like your own whose members have a significant involvement in the program. We want and need your cooperation and your advice.

I will describe the Medicare program briefly and then concentrate in my own remarks on the relationship between the Government and the practicing physician in carrying out the program.

What is Medicare? It is a health insurance program for people age 65 and over. There are two parts to the program. First, there is a basic plan for hospital and hospital-related benefits. Payment for inpatient hospital services are provided for the first 60 days of a spell of illness with an initial deductible of \$40, and payment for 30

additional days is provided with co-payment by the patient of \$10 a day. The services covered are those ordinarily furnished by hospitals to inpatients who occupy semi-private accommodations. Physicians' services are excluded from coverage in the basic hospital plan.

Payment for outpatient hospital diagnostic services is also provided. For each diagnostic study, defined as a 20-day period of diagnostic services, provided by the same hospital, the patient pays a \$20 deductible, and 20 per cent of the remaining charges for the study.

Payment for inpatient care in an extended care facility after transfer from a hospital is provided for a 20-day period, and for an additional 80 days with a co-payment of \$5 a day by the patient—for a total of 100 days during any spell of illness. Here, too, all ordinary services of a qualified skilled nursing facility in semi-private accommodations are covered.

And lastly, payment for post-hospital home health services is provided for up to 100 visits during the 1-year period after discharge from a hospital or extended care facility and before the beginning of the next spell of illness. A spell of illness begins on the first day an eligible person receives covered services in a hospital or extended care facility. It ends when he has not been a patient in a hospital or extended care facility for 60 consecutive days.

These basic hospital benefits are automatically available to all social security and railroad retirement beneficiaries who are 65 years of age. They will also be available to those people now 65 or who will attain 65 before 1968 under certain deemed entitlement provisions in the law, even if they would not ordinarily qualify as social security or railroad retirement

beneficiaries.

We expect that on July 1, 1966, when these benefits, except for services in an extended care facility, become effective, 19 million aged people will be qualified to receive them. That's a lot of people. And you may well be thinking how are we going to accommodate them all. I can't give you the whole answer. But there are a number of provisions built into the law to try to prevent overutilization of services, for example, limitations on coverage, specific exclusions from coverage, deductibles and co-payment provisions, physician certification, and best of all, perhaps—the fact that different types of health services are covered. We hope this will create a strong incentive for both the patient and the doctor to utilize those services which are appropriate to the level of care which is medically required.

The second part of the program is a supplementary plan, providing for the payment of medical insurance benefits. Payment is provided for physicians' and surgeons' services in a hospital, doctor's office, in the home, or elsewhere.

Under the supplementary plan, payment for up to 100 home health visits in a year are also provided, with no need for prior hospitalization. This is in addition to the 100 visits paid for under the basic hospital program. And a number of other medical and health services are covered, such as diagnostic services, X-ray or other radiation treatments, prosthetic devices, ambulance service, and the rental of durable medical equipment, to mention only a few.

The patient pays a \$50 deductible for each calendar year, and 20 per cent of the remaining expenses for all covered services provided during the year. This part of the program is not to be financed from social security contributions; the benefits it provides are not

automatic. They are available only to those who have voluntarily enrolled and agreed to pay a monthly premium of \$3 which is matched by an equal amount from general revenues.

It has been estimated that from 80 to 95 per cent of the eligible aged will wish to enroll. This would mean that approximately 15 to 18 million individuals would be eligible for supplementary benefits on July 1, 1966, when these benefits, too, become effective.

And there, generally speaking, you have the elements of the health insurance program, or health insurance policy, if you will. For the aged, it is quite a good insurance policy. For the first time in our history, the elderly population of America, as a group, will be able to purchase health insurance comparable in quality and range of services to that now generally available to younger people.

Now what is the physician's role in medicare? He is recognized as the key figure in the entire program. It will be the physician who determines what kind of care his patient needs, and whether his patient needs diagnostic services, hospitalization, skilled nursing home care, or home health services. And the physician will plan the course of the patient's therapy wherever these therapeutic services are being rendered. Nothing in the medicare legislation affects the physician's relationship to his patient or his practice of medicine. Indeed, the law quite clearly states that nothing in the health insurance provisions shall be construed as authorizing any government interference or control over the practice of medicine, the way in which medical services are provided, or the administration or operation of medical facilities. The fundamental concept of the health insurance program, which may so easily be overlooked in any debate about its value, is, that it is there not to provide med-

ical services or to supervise medical services in any way, but only to help aged people pay for needed health care, the very people that need health care the most, and that are the least able, as a group, to pay for that health care.

With respect to payment of physician's services under the supplementary medical insurance plan, there are two simple methods of payment, and the physician and his patient will agree on which one to use. The physician may bill the patient and collect from him directly. In this case, the patient sends the bill to the appropriate carrier, an insurance organization which is acting as the administrative agent for medicare in that area, and the carrier reimburses the patient.

Or, if the physician agrees, the patient may assign his right to reimbursement to the doctor, and the doctor will submit the bill to the carrier—and in this case, the carrier makes payment directly to the physician.

This might be the best system for the physician because he can be sure payment would come promptly and directly to him. But, of course, the method is optional, and the decision on which method to use would no doubt vary from patient to patient.

Under either method, however, the carrier would pay 80 per cent of the reasonable charge for services rendered. If the physician has accepted the patient's assignment, however, he must agree to accept the reasonable charge (as determined by the carrier) as his full fee. He may, of course, collect from the patient the remaining 20 per cent of his reasonable charges and any amount of the \$50 deductible still owing to him.

It will be up to the carrier to determine the reasonable charge. The carrier will take into account prevailing rates in the community as well as cus-

tomary charges by the physician for similar services.

As far as the "paperwork" that may be imposed under the program, I would like to assure you, that our procedures are being designed to conform as closely as possible to the documentation requirements of most large prepayment organizations. These are procedures with which most physicians are familiar, and which they have long accepted. What we will ask for will be the minimum information necessary to establish eligibility for payment and to determine amounts due. For physicians, a description of medical services rendered will ordinarily be sufficient.

The physician, of course, has a central role to play with respect to the institutional benefits provided under medicare. As you may know, the law lists certain conditions that hospitals, extended care facilities, and home health agencies must meet in order to participate in the program. These conditions are included to provide assurance that participating institutions are safe, that they have facilities and organizations necessary for the provision of adequate care, and that they exercise their responsibility to discourage improper and unnecessary utilization of their services and facilities. To allow payment to institutions for services of lower quality than is now generally acceptable might reduce the incentive for establishing high quality institutions, or for maintaining high standards where they now exist.

The conditions were formulated with the help of professional bodies, and are of the kind that are generally acceptable by all responsible institutions. For hospitals, for example, the law requires that they be primarily engaged in providing diagnostic and therapeutic services or rehabilitation services, they must maintain clinical records, they must have by-laws in effect for the medical

staff, they must have a requirement that every patient be under the care of a physician; they must provide 24 hour nursing service. And, they must have in effect a utilization review plan.

The provision for the utilization review plan may cause some concern to physicians.

I would doubt that any of the other conditions would. So let me say just a few words about this aspect of a hospital's or skilled nursing home's ability to participate in the program. I would like to emphasize that utilization review is conceived of primarily as an educational tool and not a regulatory mechanism. In the administration of a program financed by public funds, the Congress considered it essential that there should be a review of institutional utilization. A great deal of testimony by professional organizations supported this provision. It should be borne in mind that the utilization review function will not be carried out by governmental authorities, but by the professional medical staff of institutions, or by an outside group composed primarily of physicians and sponsored by the local medical society. We believe that the work of these committees will be entirely consistent with the desire of both institutional administrators and physicians that the use of covered services under medicare will be dictated only by medical needs.

I might say that few of us in Government have ever seen a program begin with so great a commitment to consultation as the basis for its administrative judgments. We have, and we are, continually asking for guidance, and we are carefully listening to advice. The AMA and many other professional organizations have responded and we feel more confident with that important professional resource. Whether it be called collaboration or consultation, it is, to us, constructive and crucial.

It is not only consultation to which we are committed. The law also requires participation by responsible professional agencies. In the critical process of certifying providers of services—not physicians—but institutional providers, we will work under agreements with State agencies. In North Carolina, the State Health Department was one of the first State agencies to be designated by a governor to assist the Secretary of Health, Education, and Welfare in carrying out the medicare program. This required participation at the State level is but another example of the earnest effort to enhance and elevate existing health care components, and not to create new Federal forms of organization or control.

Whether medicare is a good or a bad law may still be properly debated, but I think most of us now feel that the administration of the law is the matter to which we must turn our attention, with a shared concern that it must contribute to, and not detract from, the quality and the availability of health services for American people.

Successful Health Careers Congress

Nearly 300 high school students assembled in Raleigh on February 4-5 to attend the Fifth Annual Health Careers Congress conducted by Health Careers for North Carolina, a program of N. C. Hospital Education and Research Foundation. The purpose of the Congress was to assemble representatives of high school health career clubs throughout North Carolina to hear leaders in the health field and be afforded opportunity to consult with experts in their chosen health careers. Speakers included Dr. George Paschal, President of the Medical Society of the State of North Carolina, and Dr. James T. Cleland, Dean of the Duke Chapel, Durham.

Medicare

What It Means to Nursing Homes

by
Travis H. Tomlinson
Raleigh
President, Mayview Convalescent Home
and
Past President, N. C. Association
of Nursing Homes
and
Mayor of Raleigh

Address delivered at Annual Meeting of
N. C. Health Council.

Mr. Chairman, Ladies and Gentlemen, I am delighted to be here representing the North Carolina Association of Nursing Homes.

Many of you have read more about public law 89-97 than I and many of you have been present when its effects on nursing homes have been explained but I think this law is one that requires a lot of thinking and a lot of planning.

Actually it might be that what is **not** spelled out in the law may cause our greatest concern.

In North Carolina today we have 45 nursing homes with 2048 beds. In addition, we have 34 combination nursing and boarding homes with 1428 nursing home beds and 1480 boarding home type beds. This makes a total of 3476 nursing home beds now available. In addition we have approximately 15 homes under construction or in the planning stages which would provide approximately 800 additional nursing home beds by January 1, 1967, the effective date when this law would cover care in nursing homes.

In my personal opinion our largest single problem is that of determining at what point in a patient's illness his needs should and could be best met in the nursing home.

If we assume that there will be about 4300 people in nursing homes on January 1, 1967, and we add to this some 7 to 10 thousand now in boarding homes, we are dealing with approximately 14,000 people in the two type homes.

Now we have to put these together in order to make my point. Medicare will pay only for care in the skilled nursing home but the question is—how many of these 14,000 people in all type homes on January 1, 1967, will be eligible for Medicare payments?

It is safe to say that there are people in skilled nursing care homes whose needs could be met in a boarding home

and there are certainly people in boarding homes who need skilled nursing care. There are also people in the hospital whose needs could and should be met in the nursing home. But, let's deal with this 14,000 we started talking about.

We have or we will have on January 1, 1967, about 4300 nursing home beds that will qualify for Medicare payments. The number of these 14,000 people to qualify for nursing home

payments may vary considerably according to final determination as to just what constitutes "skilled nursing care."

There has been much discussion and many meetings over the years to determine just what diagnosis and what treatment procedures should be available in the nursing home. We in North Carolina feel that we have arrived at a fairly good solution to the problem but even then this decision may or may

MRS. DAN K. MOORE VISITS HEALTH EDUCATORS' MEETING

During Mrs. Moore's recent visit to the State Board of Health, she listened in on the regular monthly meeting of Health Education Workers which was going on that day. Shown in the picture, from the left are: Mrs. Mary Brodie, Mrs. Lula B. Rich, Miss Barbara Kahn, Dr. Jacob Koomen, Mrs. Dan Moore, Miss Nettie L. Day, Dr. Burns Jones, Mrs. Georgia Barbee, Miss Ruby Isom, Miss Grace Daniel.



not coincide with those finally adopted by H.E.W.

In most cases money has been one of the principal considerations in deciding whether the nursing home or the boarding home was to be used for care of a patient. This has been true regardless of the source of the patient's funds—either private or welfare. The emphasis has been on keeping the patient in the least expensive place.

The better staffed nursing homes did not want welfare patients because they lost \$50 to \$100 per month on each one. The doctor was somewhat confused on the "skilled nursing care" classification anyway and he, of course, responded somewhat to the desires of the patient and family.

Now let's look at one extreme end of what may happen. Mr. Hess of the Social Security Administration told the American Nursing Home Association people in Chicago that nursing home care would be provided **only in connection with the extension of hospital care and under a very well defined program**. It is believed that this was the intent of Congress and, of course, this would mean a somewhat limited nursing home program.

So you can see from these very limited remarks that depending on the regulations which are yet to come from Washington, the percentage of these 14,000 people now in these various type homes in North Carolina who will qualify for nursing home care may vary considerably. Authorities in hospitals say the patients over 65 in the hospital will increase from 10 to 40 per cent by using Medicare. Actually, we do not know how many nursing home beds will be needed and we will not know until all the regulations are written. Another factor at this point—North Carolina as you know has standards for nursing homes different from those for boarding homes. This is not

true in most states. We **think** that in this connection we are far ahead of many other states, however, under the provisions of this law the Federal government has the legal authority to in effect re-write all of our regulations.

I will brief a few points now and leave the balance of the time for questions.

Extended care in nursing homes is available only after a minimum of 3 days in a hospital and then for 20 days with no charge to the patient and after that for 80 additional days with the patient paying \$5 per day. This allows a maximum of 100 days per "spell of illness" and this "spell of illness" is not concluded until 60 days of "no coverage" under the program. We presume 3 more days in the hospital would be required before going back in a nursing home. For all practical purposes all nursing homes will be integrated.

Transfer agreements between hospitals and nursing homes will be needed. Details will follow.

Nursing homes must have nurses around the clock with at least 1 full time R.N. This has been true in North Carolina for some time. The shortage of RNs will be felt in nursing homes as well as in hospitals.

It is not contemplated that any payments will be made under Medicare to what we call boarding homes in North Carolina.

Broad authority is given to the Secretary of HEW to establish criteria for nursing homes. In addition to meeting the State requirements, HEW'S must also be met. In North Carolina it is felt that our Health Department standards are high enough to meet the HEW standards but we do not know.

Accreditation may or may not be required.

This nursing home benefit is for semi-private accommodations. It is assumed that the difference in cost be-

tween semi-private and private rooms may be paid by the patient or others.

The utilization review procedure is approximately the same in the nursing home as outlined for the hospital. Payments to nursing homes will be equal to the "reasonable cost" of services provided. Most nursing homes are now considered profit ventures. Such questions as these are asked: (1) Will reasonable cost include payment of interest on borrowed money used to finance construction? Answer—We assume so but we do not know yet. (2) What about profit? This answer is not at all clear. Public utility companies are permitted to include what may be considered profits and these companies are controlled by government regulations.

I will quote one sentence here taken from a comment by Social Security authorities. "Although payment may be made on various bases, the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the cost of services of individuals covered by the program will not be borne by individuals not covered, and the cost of services of individuals not covered will not be borne by the program."

Expenses for bad debts will not be allowed.

Nursing homes will be required to maintain good cost accounting procedures. This program has been started in North Carolina but much work is yet to be done.

The licensing agency will be needed to assist in working out many detail provisions of the law and I'm sure it will.

The roll of "Fiscal Intermediary" is about the same for nursing homes as for hospitals.

What Is a Stroke?

A stroke occurs when the blood supply to a part of the brain is reduced or completely cut off.

This can be caused by a blood clot or by hemorrhage—bleeding from an artery in the brain. Medical terms used for various kinds of strokes are cerebral vascular occlusion, cerebral thrombosis, cerebral embolism, and cerebral hemorrhage.

When the nerve cells of a part of the brain are deprived of their blood supply, the part of the body controlled by these nerve centers cannot function normally. The results may be weakness or paralysis, difficulty in speaking, or loss of memory.

Some patients recover quickly, and can resume their normal activities. Others may suffer such serious damage that even a partial recovery will take a long time. Immediate treatment with proper exercises and other forms of therapy can do much toward helping a patient regain the use of muscles and speech.

If a stroke is brought on by a narrowed blood vessel or, in some instances, a blood clot, the doctor may use anticoagulant drugs to prevent another stroke. When neck arteries leading to the brain are involved, a surgical operation can sometimes remove the obstruction to circulation.

Rehabilitation for stroke requires the cooperation of the doctor, the patient, and the family. The patient's own will to avoid invalidism and to become independent is especially important.

American Medical Association
Chicago, Illinois



Fontana Dam near where the annual meeting of the Western North Carolina Public Health Association will be held May 12-13.

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How's Your Legal Health?

Just as it is a good idea to see your personal physician for an annual medical examination, it is also wise to consult your lawyer periodically for a legal checkup.

Why? To protect yourself and to ease your mind about your legal status. One lawyer has stated, "If more people got legal checkups regularly, 90% of all litigation would be eliminated overnight.

What does a legal checkup involve? Your lawyer will ask you to fill out a questionnaire giving specific information, such as the location of important papers and whether you have married or remarried since making your last will. Together you will examine your legal documents: contracts, title to your home, mortgage papers, tax records, and insurance papers, for example. This will take only an hour or so of your time and cost \$15 to \$20.

Later you may be presented a written opinion by your lawyer which will tell you where you stand legally. If you need to take legal steps to protect yourself, it will so state.

Some questions you might ask yourself to determine what you know about your legal status are:

—Do you have copies of your income tax returns for the past four years?

—If you don't have a safety deposit box, where do you keep important papers so that they will be safe from theft and fire?

—Can you give names of persons who could provide complete information regarding your affairs, assets, and liabilities in the event of your death or serious incapacity?

—Has your wife (or husband) executed a will, and is it in accord with plans made in your will? If she has not made a will, have you considered the possibility of simultaneous death,

or other reasons why she should do so?

—Do you know if all instruments pertaining to your real estate transactions have been recorded?

Even if your lawyer finds nothing wrong with your legal health, you will feel confident that your affairs are in proper order.

Donald W. Lewis, "Your Legal Health" Senior Citizen, January 1966
Washington, D. C.

A large number of young men are being rejected from military service because of heart and blood vessel ailments, and a good many more are receiving disability discharges from the armed forces because of these ailments. The North Carolina Heart Association says that 307,500 men in military age bracket were rejected for service in World War II for this reason.

COMPOSTING PLANT PROJECT STARTED

Under the agreement, TVA will design, construct, and operate a composting plant at Johnson City to process that community's daily production of refuse and untreated sewage sludge, amounting to about 60 tons. The plant will attempt to find an economic use for the finished product, in the form of soil conditioners and fertilizers, to offset disposal costs. TVA has had long experience in soil and fertilizer matters through operation of the National Fertilizer Development Center at Muscle Shoals, Alabama.

The Johnson City project is one of the initial activities being carried out under the new Solid Waste Program of the Public Health Service. The Office of Solid Wastes was established to administer the new Program authorized by the Solid Waste Act of 1965.

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DATES AND EVENTS

April
24-25—N. C. Conference for Social Service, Hotel Sir Walter, Raleigh.
26-28—American Industrial Health Conference, Detroit.
27-28—American Pediatric Society Annual Meeting, Atlantic City.
27-29—Eastern District NCPHA, Goldsboro.
28-29—President's Committee on Employment of the Handicapped, Washington, D. C.
29 - May 1 — N. C. Society of Medical Technologists Convention, Win-

ston-Salem.
30 - May 4—N. C. Medical Society Convention, 112th Annual, Asheville.
April or May—American College Health Association, San Diego.
May
2- 5—N. C. Congress of Parents and Teachers, 45th Annual, Winston-Salem.
3-21—World Health Assembly, Geneva, Switzerland.
1- 7—MENTAL HEALTH WEEK — In Canada and U. S.
4- 8—N. C. Dental Society Convention, 110th Annual, Pinehurst.
5- 6—Ninth Annual N. C. Planning Conference, Institute of Government, Chapel Hill.
5- 6—N. C. Association of Medical Record Librarians Convention, Winston-Salem.
5- 7—N. C. School Food Service Ass'n. Convention, Greensboro.
6-11—National Health Forum, Americana Hotel, New York.
8-19—17th Annual Meeting & Scientific Sessions of N. C. Health Association, Jack Tar Hotel, Durham.
9-11—American National Red Cross, San Diego.



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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March 1966

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JOHN HOMER HAMILTON, M.D.

June 13, 1888 — March 20, 1966

Dr. Hamilton, for nearly a half century a pioneer in public health, former Assistant State Health Director, Director of the State Laboratory, and Editor of THE HEALTH BULLETIN, died March 20, 1966. (See stories elsewhere in this issue).

Dr.

John

Homer

Hamilton

Noble

Public

Health

Pioneer

Dr. John Homer Hamilton of Raleigh, N. C., for nearly a half century a pioneer in public health in North Carolina, died at his home early Sunday morning, March 20, after a brief illness. His funeral was held Tuesday afternoon,

March 22, at 2:00 p.m. in the White Memorial Presbyterian Church. The Rev. Mr. Polk Moffett, Associate Minister, officiated. Interment was in Montlawn. Members of the Raleigh Academy of Medicine were Honorary Pallbearers.

Dr. Hamilton was born in Ash Grove, Mo., June 13, 1888. He graduated from Oklahoma Agricultural and Mechanical College in 1910; taught science in Cherryvale, Kansas 1910-1911; served as a chemist at the Institute of Animal Nutrition, Pennsylvania State College, 1911-1912; entered the Harvard Medical School in 1912, and graduated with a medical degree in 1916.

After graduating from Harvard, he served as Associate Bacteriologist, Division of Laboratories and Research, New York State Department of Health, 1916-1918. He then became Associate Professor of Preventive Medicine and Assistant Director, State Public Health Laboratory, University of Iowa, 1918-1919. He served as Associate State Director, International Health Division, Rockefeller Foundation, 1919-1920.

Dr. Hamilton came to North Carolina in 1920 and served as New Hanover's Health Director. In 1931 he came to the State Board of Health, becoming in 1933 the second Director of the Laboratory Division, in 1942 Editor of The Health Bulletin, and in 1951 he became Assistant State Health Director.

He had served as president of the North Carolina Public Health Association, the North Carolina Academy of Public Health and the North Carolina Academy of Preventive Medicine. He was a member of the Raleigh Academy of Medicine, the Wake County and North Carolina medical societies, the American and the Southern medical associations, and a charter member and fellow of the American College of Preventive Medicine.

Dr. Hamilton maintained his interest in non-medical affairs and was a mem-

ber of the North Carolina Harvard Club, Executives Club of Raleigh, the State Literary and Historical Association and the North Carolina Society for the Preservation of Antiquities.

Among tributes paid to Dr. Hamilton were these:

Dr. Jacob Koomen, North Carolina's Acting State Health Director, paid this tribute to Dr. Hamilton, "Perhaps no single personality has made as lasting an impression on public health in North Carolina as has Dr. Hamilton. His quiet strength and his high professional competence combined to make him a respected leader in the medical and public health relationships."

Dr. J. W. Roy Norton, former State Health Director and long-time friend of Dr. Hamilton, issued this statement: "All North Carolinians have many reasons to be grateful for the public health services of John H. Hamilton. His primary purpose was to assist the private medical practitioners to provide the best possible service to their patients—through both treatment and the prevention of disablement.

"As New Hanover County Health Director, designer and director of improved State laboratory facilities, Assistant State Health Director, and promoter of local health departments and local laboratories, Dr. Hamilton has had a key role in decreasing fear and sorrow and in bringing happiness and progress to countless homes. His co-workers will long remember the encouragement and the thoughtful and warm helpfulness he cheerfully gave. He lived a demonstration of the harmony of the art and science of medicine and of science and religion."

Dr. Hamilton is survived by the widow, Mrs. Hamilton, the former Aline Brigman; a son, John H. Hamilton, Jr., Cary; a daughter, Mrs. Lyn Evans, Charlotte; a son, Lewis F. Hicks, Rocky Mount; and four grandchildren.

An Echo from a Dedication

The auditorium of the Laboratory Division of the State Board of Health—newly redecorated and attractively refurnished—was dedicated in 1963 as the John Homer Hamilton Auditorium.

Dr. John R. Bender, physician of Winston-Salem and the then Vice-President of the State Board of Health, made the principal address at the dedication of the John Homer Hamilton Auditorium. Here is a part of Dr. Bender's tribute to Dr. Hamilton.

"Many introductions have been given, many eulogies written and many laudable comments made concerning (Dr.) John Homer Hamilton. And a voluminous treatise, yet to be given would not portray the entirety of his achievements or the benevolence of his humanitarian character. I will make no attempt therefore to proffer a laudation in his presence or on his behalf. But I would be derelict in my duty on behalf of the State Board of Health and personally negligent to those grateful emotions which arise within me if I did not express to Dr. Norton, and to

you, the members of the staff and the N. C. Public Health Team of the State Health Department of which Dr. Hamilton was for so long a member and all of whom he so dearly loved, my deep and sincere appreciation for the opportunity to attend this meeting—and my gratitude in having this honor as a representative of the State Board of Health, to pay tribute to a personal friend and an esteemed colleague.

"My association with Dr. Hamilton—extends back over a period of 14 years—and during this period of time I have marveled at his judgment and the effective dispassion with which he presented his position—regardless of the issue. His freedom from personal bias and mundane motives—gained him the unselfish admiration of the members of the State Board of Health.

"Dr. Hamilton's career in North Carolina as a public health physician is the more remarkable when we consider that he was born in Missouri, reared in Oklahoma, taught public school in Kansas; and came to this State—of his own choosing—by way of Pennsylvania. And we will be ever grateful to him for the choice he made 43 years ago; when he chose to end his journeying and settle in the Tar Heel State. Dr. Hamilton—brought to the banks of the Cape Fear and the Atlantic Seaboard the intellectual curiosity befitting a native of the "show-me" state of Missouri; the enduring stamina and strong physique of a frontiersman of the western plains of Kansas; the sagacious courage common to a denizen of the Oklahoma Territory; the analytical mind of a research fellow of the Rockefeller Foundation, the cultural background of a professor of chemistry at Penn State and the clinical acumen of a Harvard Medical Graduate. This composite young physician was worthy and well qualified, to take over the directorship of the Laboratory of Hy-

giene in 1933 and in 1951 to assume the duties of Assistant State Health Officer. Both of these positions he held concurrently until 1960.

"Dr. Hamilton discharged the duties of these separate departments with outstanding service to this State; with intellectual perspicacity to the departments, honor to the medical profession and international acclaim to the N. C. State Health Department, and the State Board of Health. Therefore it is befitting the integrity of this outstanding humanitarian—who has devoted a lifetime to the ministry of public health—that we should assemble here today; in this room—of which he is a legendary part, and which his presence halos to unveil this plaque and dedicate this auditorium—which 'honors the dedicated service to public health of John Homer Hamilton, M.D.—'".

The Health Bulletin

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Vol. 81 March, 1966 No. 3



DR. LYNN G. MADDRY BECOMES DIRECTOR OF THE LABORATORY DIVISION

In an official ceremony in the John Homer Hamilton Auditorium on March 7, Dr. Jacob Koomen, Acting State Health Director, announced the appointment of Lynn G. Maddry, Ph.D., M.S.P.H., as Director of the Laboratory Division. Dr. Maddry has served in various capacities with the State Board since June, 1931 and most recently as Acting Director of the Laboratory Division. Dr. Maddry (right) is shown with Dr. Koomen and Mrs. Corrina (David B.) Sutton, who was named Acting Assistant Director of the Laboratory.

Medicare

What It Means to Hospitals

by

Marion J. Foster

Raleigh

Executive Director

N. C. Hospital Association

The enactment of Medicare, together with other major programs included in P. L. 89-97, will have a far reaching impact on the nation's non-federal hospitals when it goes into effect next July 1. With the enactment of this law the United States is moving into a new era of health prepayment.

This new legislation, aimed at the provision of the best possible health care for our aged citizens, will demand the greatest adaptation ever experienced in the history of the hospital field if we are to preserve the voluntary system we value so highly.

In my opinion, this law is a manifestation of some deep cultural and social changes taking place in the United States. These changes will have long range significance and will test the validity of the voluntary hospital system. I do not believe that these changes invalidate the concept of the voluntary hospital system.

I do think, however, that we will be faced with some major problems in trying intelligently and effectively to adapt our health system to this changing social, cultural, and economic environment. This adaptation will require unparalleled changes in our present system of health care.

Relationship Between Voluntary System and Government

One of the most dramatic changes will be the alteration in the delicate balance so long established between government and non-government systems of financing health care. Historically, we have been unique in this nation in maintaining this sensitive balance between government and private endeavor in the provision of health services. We have opposed an all-government system while on the other hand we have recognized the defects of uncontrolled and irresponsible private mechanisms.

This partnership which has existed

Presented December 7, 1965 to Annual Meeting of N. C. Health Council meeting in Durham.

in the past between government and voluntary effort in the provision of health care is now at a critical point. It has never been as important for us in the hospital field to preserve it as it is now. While in our judgment the Medicare law has some serious defects, it need not totally upset this partnership and indeed we must see that it does not.

Fortunately, the law does permit maximum use of our voluntary prepayment system. The hospital field and Blue Cross have argued vigorously for a pattern of implementation that would avoid the creation of a Medicare machine outside of this voluntary structure which we have developed so carefully and successfully over the years.

Financing by the Federal Government

Perhaps the matter of greatest concern to hospitals is reimbursement for care of patients covered under Medicare. For the first time a Federal law has clearly stated the intent of Congress that hospitals must be reimbursed for the "reasonable cost" of their services. This is significant and should provide reassurance to hospitals.

In direct contrast to attempts made in the past by Government agencies, particularly state and local agencies, to pay hospitals less than the cost of their services, Congress has stressed that the cost to be reimbursed under this law will be full reasonable cost. The law specifically provides for payment of reasonable cost in all of its sections including the amendments to Kerr-Mills, Title XIX.

Improper payment by the Government for the cost of care of those for whom the Government has assumed responsibility has long been an unfair burden on the others who used the health facilities in our nation. This has been particularly true in North Carolina. Now adequate reimbursement will do much toward supporting the high

standards that are the aim of our hospitals in providing care to all citizens.

We must also keep in mind that the law provides that payment for services to Medicare beneficiaries must be related to the cost of the services utilized by them. The cost of services to these beneficiaries will not be borne by individuals not covered by Medicare and the cost of services to individuals not covered under the program will not be borne by Medicare. This makes it more necessary than ever that hospitals be able to show by facts and figures the propriety of various elements of the cost.

What do we mean by "reasonable cost?" The law provides that in establishing the reasonable cost of services the Secretary of HEW shall consider principles established by national organizations concerned. The American Hospital Association for many years has approved a set of Principles of Payment for Hospital Care. These have been constantly studied, revised from time to time, and have stood the test of use by all kinds of agencies, public and private.

The American Hospital Association is currently negotiating with HEW on behalf of member hospitals to establish the elements of reasonable cost based on these principles. Hospitals throughout the nation were asked to sign a "declaration of intent" naming the AHA to perform the role of negotiator. Ninety-eight percent of hospitals returning the declaration of intent requested AHA to do this negotiating on their behalf.

Intermediaries

Another matter of much importance to hospitals is the administrative (fiscal) intermediary between the hospitals as providers of service and the Federal government. The law provides that such intermediary may act in a variety of ways. The role could be narrow or

broad. Hospitals have urged that the role of the administrative intermediary be made broad, being more than a simple conduit for checks.

Perhaps the most crucial decision for the Secretary to make is the selection of administrative intermediaries and the assignment of functions to them. The law provides that the Secretary of HEW may utilize an administrative intermediary nominated by the providers of care if he determines that the use of such an intermediary is, among other criteria, "consistent with the effective and efficient administration" of the law. The Secretary, therefore, has wide latitude in assigning responsibilities to the intermediary.

The providers of care, particularly the hospitals, will have a great deal to say about what agency is nominated to fill the role of intermediary and the scope of responsibilities ultimately assigned to it. Ninety-nine percent of those hospitals returning a declaration of intent to the American Hospital Association designated the Blue Cross Association and its member plans as the administrative intermediary. This nomination has officially been transmitted to the Social Security Administration by the American Hospital Association.

In my opinion, the jobs to be done by an intermediary would include the following:

1. The determination of eligibility and benefit availability
2. Administration of claims
3. Audit of hospital costs
4. Administration of the reimbursement formula in the individual institutions
5. Maintenance of utilization records on an individual and collective basis
6. Conduct of studies concerning utilization and assisting in utilization control through appropriate organizations

(This function may well overlap with those of the state certifying agency.)

7. Preparation of statistical reports as requested by the Social Security Administration. These would also serve the general purpose of assisting hospitals to maintain a high level of performance under the act.
8. Assistance to hospitals and health care institutions in record keeping, accounting, and other administrative functions as required in the legislation
9. Assuring general conformance to requirements by all participants in the program
10. Communication to individual hospitals all regulations, interpretations, and instructions pertaining to implementation of the Act.

Utilization

What effect will the law have on utilization of hospital services? The immediate reaction of the average citizen when confronted with Medicare's impact on our hospitals is, generally, that hospital beds will be filled to overflowing with the aged. There is general belief that many of our aged citizens will be postponing hospitalization until July 1.

There are varying opinions from the experts as to the increased patient load as a result of the program. No one can be completely certain as to what effect the program will have on hospital bed needs. The aged are not a new body of people who have suddenly appeared on the horizon. The needs of the aged for hospital facilities have been considered generally in hospital bed need projections developed over the years.

Experience has shown that whenever financial barriers are removed, either with voluntary or governmental programs, the use of facilities increases

to some extent. I do not believe, however, that implementation of Medicare will produce a swamping of our hospital facilities.

While there may be some overcrowding of facilities in the initial stages of the program, there will be factors working against any gross overuse in the long run. The first of these will be the continuing need for care by the acutely ill among persons, young and old. It is highly unlikely that hospital medical staffs will allow large numbers of elderly patients to occupy hospital beds unnecessarily when they need beds for other patients. I think that medical staffs themselves will generate considerable pressure to make utilization review work.

The utilization review provision hopefully will act as an important safeguard against the intake of patients with no real need for acute hospital

services. The provision also makes it definite that no patient is to remain in the hospital after he no longer has need of such acute hospital service.

A second factor is that two major "relief valves" for general hospitals are contemplated in the program: extended care facilities and home health care programs. We must be constantly aware, however, of the time gap between the implementation of Medicare for hospital services and payment for such care in extended care facilities or in the home. Pressures are going to be brought on all of us because of this delay in the financing of this extended care. It will put hospitals, physicians and extended care facilities to the test.

The effective functioning of utilization review programs will definitely require a carefully planned administrative mechanism in each hospital. Further, the requirement for utilization re-



STATE STAFF LEADERS CONGRATULATE NEWLY APPOINTED DIRECTOR OF LABORATORY DIVISION

State Staff Leaders who were present to congratulate Dr. Lynn G. Maddry upon his appointment as Director of the Laboratory Division are shown here. From the left, these are: Dr. James F. Donnelly, Epidemiology; Ben Eaton, Administrative Services; Mrs. Corrina Sutton, Acting Assistant Director of Laboratory; Dr. Maddry; Dr. Jacob Koomen, Acting State Health Director; Dr. E. A. Pearson, Dental Health; Dr. W. Burns Jones, Acting Assistant State Health Director; and J. M. Jarrett, Sanitary Engineering.

view will bring about a more discerning examination of medical practices in our hospitals. This control has wisely been designed to be flexible enough to permit adaptation as our experience with the law develops.

The program at the present time makes no provision for constructing new facilities or altering existing ones. We must guard against any widespread expansion in general hospitals without carefully documented need. Areawide planning, aimed at using wisely the beds available at the present time, should be encouraged.

I think we may anticipate that many hospitals will undertake the operation of extended care facilities and also develop home health service programs. Some hospitals may even reorient use of some of their existing hospital beds to provide extended care facilities. This should be a time for caution and watchfulness and not a time for building additional general hospital beds on the belief that "all our beds will be filled with old people."

Effect of Utilization on Costs

It must be recognized, however, that the removal of longer staying patients from general hospital beds may well have a decided effect upon the cost of care in general hospitals. While we may be able to accommodate more patients in each acute bed within a given period, there is ample evidence to indicate that hospitals that do accommodate more patients per bed per year have appreciably higher costs.

Development of Outpatient

Departments

The new law gives the force of government to the development of hospital outpatient facilities. This force coincides with the increasing public demand for the full range of physician services in hospital outpatient facilities. This pressure will undoubtedly result in

more rapid development of such facilities in the future.

Relationships Between Hospitals and Extended Care Facilities

The law requires that acute short-term general hospitals and extended care facilities establish a formal relationship. Such an arrangement would be specifically designed to continue the care which the patient received initially in the short-term general hospital. The establishment and maintenance of the level of care expected in extended care facilities as "sub-hospitals" will be helped by organized means for exchange of information, by joint medical staff interest, and by the extension of teaching programs from general hospitals to these facilities.

Accreditation

One salutary effect of Medicare will be an upgrading of standards in hospitals all over the nation which plan to participate in the program. Hospitals accredited by the Joint Commission on Accreditation of Hospitals will in most instances automatically be qualified if they meet the utilization review requirements prescribed. Congress has given full recognition to the accreditation of hospitals by the Joint Commission and has provided that the Commission's standards should be required of any facility entitled to be designated as a hospital.

Unaccredited hospitals as well as nursing homes and home health agencies will be tested by criteria set out in the statute or within limits specified by the Secretary of HEW in regulations. If an institution is found to be ineligible, there will be opportunity for consultation and for the remedying of any deficiency.

The State Board of Health has been designated in North Carolina, as in most other states, as the agency to certify the eligibility of institutions to participate in the program. It is anti-

cipated that a major function of the Board will be with respect to consultation with hospitals concerning utilization review.

It is encouraging that the Joint Commission on Accreditation of Hospitals has established a program of accreditation of nursing homes effective January 1, 1966.

The intent throughout the law is that the Secretary will relate his conditions for participation to recognized professionally established standards. Higher standards stemming from this Federal action will have a chain reaction so that all forms of facilities involved in caring for the aged will be improved or forced out of operation.

Impact on Personnel

We must consider the manpower situation when regarding the impact of Medicare on our hospitals. Current critical shortages of hospital personnel will be further magnified as greater financing will encourage increased use of all health facilities, particularly extended care facilities.

Hospitals generally have not increased salaries to keep pace with other industries. In the future greater attention will most surely be drawn to this situation. Some experts believe that the pressure may well require that hospitals redirect their priorities for spending. This may require a de-emphasis of new facilities and new services in favor of increasing the salaries of certain personnel. This will have the effect of increasing hospital costs even more rapidly than they have in the past.

Relationship of Certain Specialists and the Hospital

Another matter of major concern is the reimbursement for the services of certain hospital-based specialists. Hospitals have actively opposed the transfer of payment for the services of certain physician specialists from Part A

of the law to Part B. Historically, we have maintained that local option on this matter has been of significant benefit to the patient, to the hospital, and to the physician. We believe that any arrangement determined at the local level that does not exploit patient, physician or hospital is proper.

The problems for all hospitals with respect to medical specialist payments will be considerable, although they may differ from hospital to hospital. For example, those that pay salary to a specialist will have to remove the salary from the cost submitted for reimbursement of care to the aged. If the specialist bills the government for his services, the deductibles required by the law will have to be applied and adjustments made in the salary arrangement in order to equate the additional income.

Hospital leaders generally feel that the removal of specialists' services from hospital services is a backward step and one which will jeopardize continued improvement in the quality of patient care in hospitals. They contend that the best possible patient care at the lowest possible cost will require increased concentration of a wide variety of highly skilled health personnel in hospital centers, rather than fragmentation of these services.

These integral services cannot be separated from other hospital services without affecting the quality and cost of care. Further, the aged patients will not understand the deletion of the specialist services from their hospital benefits. Such misunderstanding will in turn cause administrative difficulties which will be reflected in increased cost.

There is a possibility that the Department of HEW may rule that the supervisory, educational, and administrative functions of specialists are hospital services, and properly to be reimbursed

under Part A.

Collateral Benefits

There are perhaps some benefits to be derived from Medicare which are not readily seen. For example, there is a possibility that Medicare may bring about a more realistic pricing of individual hospital services according to their cost so that the public knows what it is paying for and hospitals can avoid the unfounded but reasonable sounding charges of profiteering.

SUMMARY

No one can begin to question the momentous effect this new and revolutionary Medicare law will have on our present hospital system. Although we can already formulate a fairly inclusive view of many of the far-reaching implications of the law, the full impact cannot be ascertained until the law has been put into full operation.

A new era in the history of hospitals is dawning which will require some unparalleled changes in our voluntary hospital system in order to adapt to it.

Checks and stipulations incorporated in the law will attempt to act as a safeguard against any sudden and unmanageable intake of patients into our hospitals or their unnecessary stay, but how effectively these will work will be

dependent upon how wisely they are utilized.

Hospitals will derive benefit from the reimbursement of full "reasonable cost" which will enable them to improve their facilities and maintain high quality of care.

The standards required by the government for participation in the program will encourage more than ever our hospitals and other health care facilities to reach accreditation and upgrade the quality of health services.

In the future the control of hospital and physician care financing will be in fewer hands. There will be greater controls placed on the hospitals and more assurances about how the money will be spent by the hospitals.

Even though government will be playing a large role in our hospitals' financial picture, the continuation of voluntary financing will still be of increasing importance to hospitals. Voluntary financing mechanisms will need to exert more energy if they are to survive.

Mrs. Martha Jacobson of High Point is shown examining a slide test for syphilis in the recent Syphilis Serology Seminar and Workshop conducted for 120 Laboratory Technicians from throughout the State.



Air Pollution and Health

by **B. M. DRAKE, M.D.**, Director,
Gaston County Health Department

- I. Man can survive for about forty days without food, for about seven or eight days without water and for about eight minutes without air. In one day's time a man will ingest around forty pounds of air, four and one-half pounds of water and two and three-fourths pounds of food.¹ The direct association between health and contaminated food and water has been for years a major concern of those in the health professions and much progress has been made in reducing the incidence of diseases associated with these. However, in spite of a few isolated efforts in this direction, the health professions and the pub-

Mr. Earl Adams and Mrs. Edna Earle Maness from the serology laboratories of North Carolina Memorial Hospital at Chapel Hill and Rex Hospital at Raleigh, respectively, practice VDRL slide procedures during the recent Syphilis Serology Seminar and Workshop attended by 120 Laboratory Technicians from over the State. Instructors (standing), Bryan R. Reep of the Laboratory Division Certification and Training Section and Ernest T. Creighton, Consultant for the Venereal Disease Research Laboratory Division Certification and Training Section and Ernest T. Creighton, Consultant for the Venereal Disease Research Laboratory in Atlanta, observe test technique.

lic at large have regarded the supply of clean air as inexhaustable and its pollution as of little consequence.

Hippocrates several centuries before Christ observed the effects of the "winds" on the incidence of certain diseases in certain cities.² In 1661 John Evelyn published a treatise¹ on the widespread effect of burning soft coal and peat in London, and at one time the death penalty was invoked on the use of soft coal in London.

Increasing urbanization and the industrial development accompanying the invention of the steam engine made air pollution a more widespread problem in some areas. Smoke abatement efforts were started in Europe late in the 19th century and smoke abatement ordinances were passed in a few U.S. cities during the 19th and early 20th centuries.

However, air pollution did not become a major item of concern to public health officials until the Donora, Pa., disaster in 1948. Since that time increasing attention has been given air pollution as a major cause of death and disability.

- II. Anyone who is at all familiar with the problem of air pollution is aware of the severe pollution episodes which have occurred in



Donora, Pa., in 1948 with twenty deaths and 6000 cases of illness attributed to the pollution, and in London on several different occasions when there were in 1952, 1956 and 1962 thousands of persons dying as a result of the problem. In New York City in 1953 there were 200 deaths attributed to a ten-day smog.

The unique experiences of Los Angeles in air pollution have served as an example as to what can happen in a major metropolitan center unless and until strict control measures can be taken. The long-range effects on the health of a population exposed to "sub lethal" doses of the various pollutants have not been clearly documented, but various authorities feel that there is a definite association of increased rates of chronic respiratory disease, pulmonary edema (excess fluid in the lungs) with accompanying heart strain, respiratory cancer, and asthma with an increase of certain noxious substances in the atmosphere.

III. It has been pointed out in the "Manual of Air Pollution"³ that the physical characteristics of the various substances found in the air

have considerable influence on the possible effects that may be observed in man. Particle size, solubility of gases, irritant or corrosive qualities are all of importance. In this relationship it should be recalled that the respiratory tract is composed of, first, the trachea and bronchi which are lined with thick layers of epithelium (cells similar to those which compose the skin) equipped with cilia (hair-like projections from cells) and mucous glands; and, second, of the alveoli, or air sacs, which number about 108 separate units. These have very thin walls (possibly one cell thick) which separate them from the capillary (very small blood vessels) system.

When larger particles and/or soluble gases enter the tract, the particles are washed and pushed upward and out of the body by ciliary action and the soluble substances are dissolved or absorbed by the mucous and coughed up. Smaller particles and insoluble gases, however, may go on down into the air sacs where they can either irritate and thus damage the thin wall or be absorbed through this wall into the capillary system. This action,

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which may be either mechanical or chemical (irritant) can cause fluid to pass from the capillary bed into the lungs resulting in pulmonary edema; this in turn places an additional load on the heart resulting at times in heart failure. Another possible result is damage to the alveoli resulting in an emphysematous lung (where the air sacs are injured or broken) with a decrease in the absorbing surface and resulting respiratory difficulties.

Larger particles and soluble gases can cause damage to and changes in the bronchial epithelium. Some of these may result in "bronchitis" and some in bronchogenic cancer (cancer arising in the bronchus or windpipes).

IV. According to Rihm, who wrote the section on air pollution, in the text on preventive medicine by Hilliboe and Larrimore,¹ the following disease conditions are associated with the various pollutants as follows:

A. Heart Disease—High concentrations of sulfates in the atmosphere have been shown to increase difficulty in breathing, which in turn places an increased load on the cardiac muscle. This could very easily account for at least a portion of increased mortality during acute smog episodes. Ozone with its irritant properties can cause a scarring of the epithelium of the lungs and also adds to the difficulty of breathing.

B. Lung Cancer—A number of pollutants of the air are known carcinogenic (causing cancer) agents and it is felt that this is, in addition to personal air pollution (smoking), a major factor in the increased rate of lung cancer. It has been shown that the highest incidence of the

disease occurs in areas of greater pollution of the air. In a tabulation of a partial list of pathogens (disease causing substances) found in motor vehicle exhausts Rihm lists nine compounds which are proven carcinogens. This illustrates further that there is a possibility of an increased incidence of lung cancer in areas with large volumes of automobile and truck traffic.

C. Respiratory Allergies—Asthma and hay fever are quite widespread diseases. They are generally thought to occur as the result of natural pollution of the air—pollens, dust, etc. However, manmade pollution has been shown to be a factor in increasing incidences and severity of asthma in cities with problems of pollution such as Nashville, Tenn.; New Orleans, La.; Pasadena, Calif., and Yokohoma, Japan.

D. Respiratory Infections—A definite correlation between air pollution and the frequency and severity of the common cold has been noted in cities with acute episodes of air pollution and in one instance there was a proven increased incidence of pneumonia among inmates of homes for the aged during a period of heavy pollution.

E. Chronic Respiratory Disease—A relationship between air pollution and impaired respiratory function has been established by a number of investigations. It is felt that long-term exposure to pollutants in less than acute or episodic concentrations may be contributing factors in the occurrence of bronchitis and emphysema. There has been a

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seven-fold increase in deaths in the U. S. attributed to emphysema since 1950 and the age adjusted urban rate is double the rural rate. This clearly indicates a causative factor inherent in city living.

- F. Other physical effects such as eye irritation which occurs in certain areas indicates that there may be other so-called minor results of air pollution which may or may not be of medical importance. Certainly any effort to improve the quality of the air we breath can only result in a reduction of morbidity and mortality; and we owe it to ourselves and the people of North Carolina to intensify our efforts in the direction of a cleaner air supply for all.

References: ¹Hillboe and Larrimore—Preventive Medicine, pp. 62-82 Saunders 1962

²Hippocrates — Ancient Medicine and Other Treatises Great Books Foundation, Chicago 1949

³Air Pollution Manual — American Ind. Hyg. Assn., pp. 37-43 Detroit, 1960

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DATES AND EVENTS

- 29-May 1—N. C. Society of Medical Technologists Convention, Winston-Salem.
- 30-May 4—N. C. Medical Society Convention, 112th Annual, Asheville.
- April or May—American College Health Association, San Diego.
- May
- 2- 5—N. C. Congress of Parents & Teachers, 45th Annual, Winston-Salem.
- 3-21—World Health Assembly, Geneva, Switzerland.
- 1- 7—MENTAL HEALTH WEEK—In Canada and U. S.
- 4- 8—N. C. Dental Society Convention, 110th Annual, Pinehurst.



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

51, #4
April 1966



Your family doctor: how to use him

Two leading G.P.'s say he's the key
to better care at less cost.

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— See Page 2 —

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Your Family Doctor: How to Use Him

Probably you consider one man your personal physician or family doctor. Whether he's a general practitioner, an internist or a specialist in some other field, he's the man you mean when you say "my doctor." If you asked him: "Doctor, can I help you in any way to give me better—maybe cheaper—medical care?" he would answer, "Yes!"

Here's why, as explained by Dr. Amos Johnson of Garland, N. C., and Dr. Carroll Witten of Louisville, Ky., official spokesmen of the nation's G.P.'s. Dr. Johnson is president of the American Academy of General Practice, Dr. Witten is the Academy's president-elect.

Front page picture and this article reprinted by permission from *Changing Times*, the Kiplinger magazine, (April 1966 issue). Copyright 1966 by the Kiplinger Washington Editors, Inc., 1729 H. Street, N.W., Washington, D. C. 20006.

Training and experience have taught most family doctors two things.

► When you settle for one-shot or "episodic" medical care, you buy the costliest commodity on today's health market.

► Your health care could be both better and cheaper if you used your family doctor more sensibly.

Consider your own actions. The doc-

tors say you're not getting the medical care you deserve and need if you're guilty of one or all of these too-common mistakes.

Self-referral. Nowadays there's a specialist for just about every ailment you can name, and this may tempt you to go off on your own for treatment. But if you do, you run the risk of upping the cost, often by hundreds of dollars.

Suppose, for example, severe chest pains lead you to consult a cardiologist. He must do a complete work-up—laboratory tests, X rays, physical examination and medical history—before he can make a diagnosis. If the examination fails to locate the trouble, he may recommend hospitalization and further tests.

But your family doctor already has on file not only your medical history but in all probability up-to-date results of many of those same tests. He also knows a lot about you, and other members of your family and their medical histories, your social and economic background. As a result he has a head start in hunting for the root of your trouble. And if he does find anything wrong, any indication of a problem he's not qualified to handle, he will be your referring agent, and make available to the specialist his own knowledge of you. All this can save you hundreds of dollars' worth of shopping around and unnecessary tests. He also can perform another valuable service if you ask him to—discussing fees with the specialist.

Self-diagnosis. It's easy, you say, to recognize a common cold and treat it yourself. But if that cold is accompanied by a stubborn sore throat, your diagnosis may be wrong. By delaying calling your doctor, you could be endangering your health; you're almost certainly asking for the expense of a prolonged illness that might have been minor if

caught early enough. More than one person has gotten in trouble mistaking a strep throat for a common cold, appendicitis for an upset stomach, a heart attack for indigestion.

Self-medication. If you're inclined toward self-diagnosis, this naturally follows. Once you've determined the nature of your illness, you're ready to prescribe treatment. Advice for tendencies along this line is simple: Don't. Don't take any medication that has not been specifically prescribed by your doctor. Don't assume the leftover capsules from last year's virus will do the trick for this year's sniffles. Don't rush to buy the remedy that helped your neighbor so much when he had similar symptoms. Resist the urge to cure yourself unless you have your doctor's okay. Above all, when he does prescribe, follow his orders. Take only the medicine he gives you, and only in the recommended dosage.

The most for your money

Even if you resist temptation to be your own doctor, you may still fail to get full value from your family doctor by ignoring one or more of these rules:

Have a regular checkup. It's important both to you and the doctor. It gives him the basis for comparison when something does go wrong. More importantly, it gives him the opportunity to catch at an early and less dangerous stage such major problems as heart disease and cancer, and to practice preventive medicine, which is the biggest bargain of all. In the hour or so that the examination requires, moreover, you can get valuable health education and a sympathetic ear.

Tell the truth. Surprisingly, many patients don't. They are embarrassed to tell the doctor they have seen another physician or have been doctoring themselves. It's absolutely vital to your health that he know, for example, what medicine you may have been taking,

even on prescription from another doctor. Otherwise, you may find yourself taking expensive drugs that counteract each other, depriving you of any benefits, or even worse, you may wind up with an unpleasant drug reaction. When your doctor asks what medication you are taking, he wants to know all, even if it's only aspirin.

Don't hedge, either, on any symptoms that seemed minor and have gone away. When you go to the doctor with a big problem, tell him about the little ones, too. They may provide clues for diagnosis or signal other troubles.

Be frank. If you think your doctor should consult another physician, say so. If you feel you aren't improving as quickly as you should, tell him. Only by frank and open discussion with you can your doctor know what's worrying you and move to help you. He may be able to allay your fears with further explanation of the treatment you're getting; more often than not, he'll readily agree to consultation and help arrange it for you.

Be open with him, too, on the subject of fees. If you have any questions, ask them. If you feel you have been overcharged, tell him. If he recommends a course of treatment more expensive than you can afford, say so.

It all boils down to having confidence in yourself and your doctor. He doesn't need to know about every headache or twinge; he does need to be consulted when you're ill, or think you are, and even when you're well for that regular checkup.

No matter what ails you—physical or emotional—your family doctor should be your primary contact. If he assumes responsibility for the continuity of your care, he has accepted the role of doctor, advisor and friend. Use him 100% of the time and you'll have bargain medical care, plus the very best kind of health insurance.

Dr. William A. Robie Becomes Chief of the Cancer, Heart, Chronic Disease Sections

William A. Robie, M.D., has been named Chief of the Cancer, Heart, and Chronic Disease Sections of the North Carolina State Board of Health, according to announcement by Dr. Jacob Koomen, Acting State Health Director. Dr. Robie has assumed his new duties.

Dr. Robie, a native of Maryland, came with the State Board of Health in August, 1964 as Pediatric Consultant with the Maternal and Child Health Section of the N. C. State Board of Health and served on the Clinical Staff of the U.N.C. School of Medicine, Chapel Hill.

Dr. Robie was graduated from the University of Maryland and received his medical degree from George Washington University School of Medicine. He served his Internship at the U. S. Naval Hospital at Bethesda, Maryland, and was a Resident in Pediatrics at the U. S. Naval Hospital in Philadelphia, Pa.

Following his residency, he became Chief of Pediatrics at the U. S. Naval Hospital in Hawaii and served on the Pediatrics Staff of the U. S. Army Hospital in Honolulu. Dr. Robie was Brig-

ade Surgeon in Hawaii and later became Chief of Pediatrics in the U. S. Naval Hospital, Chelsea, Mass. and Clinical Instructor at Boston City Hospital.

Dr. Robie is certified by the American Board of Pediatrics. He is a Fellow of American Academy of Pediatrics, and is licensed to practice medicine in the State of Maryland, and in the State of North Carolina.

He is a member of the American Medical Association, North Carolina Medical Society, Wake County Medical Society, American Academy of Pediatrics, North Carolina Pediatrics Society and North Carolina Public Health Association.

Dr. Robie is married to Jessie Parker of Rocky Mount. They have four children and make their home at 5437 Thayer Dr., Raleigh.

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Dr. Ben E. Washburn Is Author of A History of the State Board of Health

'A History Of The North Carolina State Board Of Health', by Dr. Ben E. Washburn of Rutherfordton, has been published by the North Carolina State Board of Health in Raleigh. The 102-page publication traces the first fifty years of organized public health work in North Carolina—a history of the State Board of Health—1887 to 1925.

Publishing books is not new to Dr. Ben, who is perhaps the senior historian in Rutherford county (and we hope he will continue to be for another generation or two). One of his early works, and perhaps one of the most popular, was 'A Country Doctor in the South Mountains', which was a history both of his early years as a physician, and of the mountain people of the South Mountain area of Rutherford and Cleveland counties.

Much of the 'Country Doctor' concerns itself with the families that lived on Cherry Mountain between Sunshine and Hollis. Some of the landmarks mentioned in the book are being restored by a group of people in and around Hollis who are interested in making the area popular as a summer home and tourist attraction.

Although his health hasn't been the best recently, Dr. Washburn is still active, and is probably more interested in the welfare of Rutherford county and its people than any other person in the county. We wish him continued success in his work, in his writings, and in his continuing search for history.

Forest City Courier



William H. Stewart, M.D.

A Profile of the Surgeon General

Picture and "contemporary sketch" printed through the courtesy of *Modern Medicine* of Minneapolis, Minnesota.

Last year was a vintage year for the 167-year-old U. S. Public Health Service. It was handed implementing, supervisory, and consultative roles in a formidable array of new national health efforts, including a share of Medicare, Regional Medical Programs, and aid to medical schools and students. The year was a turning point, too, for 44-year-old Dr. William H. Stewart, then barely

settled into the directorship of the National Heart Institute. President Johnson's search for "the most adventurous, imaginative doctor in the country" ended with Dr. Stewart's selection as surgeon general, in charge of \$2.5 billion worth of spending. Thus, many of the programs he helped prepare as a leading PHS planner became his to help make effective.

In the process, he is reshaping PHS in structure and tone and leading it in closer liaison with private practitioners for the effective delivery of health care. The national goal, he says, is comprehensive health services readily available to all.

Last year brought a clear shift of PHS emphasis from development of bioresearch, which Dr. Stewart says will continue to mature, to development of health services. PHS' function is to provide financial support, example, advice, and evaluation. "We are now in the business of developing resources for the provision of health care," he declares. "We're participating in the setting of standards for Medicare and expanded medical assistance. We help build hospitals and nursing homes and help finance medical and other professional training. Our PHS hospitals for specific beneficiary groups are going to serve as medical care administration laboratories.

"The public certainly has indicated willingness to invest in hospitals, equipment, education, and specialized personnel so their doctors can take care of them in the right way. While there is a greater public voice in the health field than ever before, I want to emphasize that decision-making must be shared. No single element—private medicine, academic medicine, or government—can write the prescription and impose it on the rest of the partnership. By providing more resources, by getting knowledge out to practitioners, by trying to demonstrate methods of increas-

ing their efficiency, we are in partnership with private practitioners."

Dr. Stewart as a youth accompanied his pediatrician father on tuberculosis skin-testing surveys in his native Minneapolis. "I boiled the needles," he recalls. After receiving his M.D. from Louisiana State University in 1945 and interning at Philadelphia General Hospital, he served nearly twenty-one months in the Army. In 1950, with a pediatric residency at New Orleans' Charity Hospital completed, he practiced in a group at Alexandria, La., before joining PHS in 1951. His PHS career has included epidemiology, with the Communicable Disease Center, supervision of community health programs, service-wide program planning, and tours as assistant surgeon general and as a high-ranking assistant to the Secretary of Health, Education, and Welfare.

Dr. Stewart sees PHS' new efforts as a reflection of a changing scene. Fragmentation of services, programs organized by disease category, and hardened professional guildism impede the growth and efficiency of health services and are historical leftovers unsuited to today's dominant health needs, he believes. Medicare is among the new efforts that can help practitioners realize aspirations for continuity and comprehensiveness of high quality care uncompromised by the patient's income, he feels. Another point he makes is that flexibility is needed in health career patterns to attract and hold competent personnel. Why, he asks, shouldn't the talented nurse have a career route into medicine? Hasn't technological advance transformed the physician from soloist into manager? In an age of specialization, who is to be the first line of family medical care—a group or a person, a new kind of family physician? These questions and others must be resolved in the attempt to meet public demands for care.

Biomedical Communications Conference Stresses Many New Methods In New York Session



Dr. Howard A. Rusk
Noted Rehabilitation Prophet

"Lives are lost by lag time—the time between newly discovered health benefits and their application at the patient's bedside."



Some Conference Speakers — From the left: Dr. Walter L. Bloom, Piedmont Hospital, Atlanta, Ga.; Dr. Seymour M. Farber, University of California Medical Center, San Francisco, Calif.; and Dr. Michael T. Romano, University of Kentucky, Lexington, Ky.

Photographs on these pages through the courtesy of *Medical World News*, the Newsmagazine of Medicine, William White, Executive Editor, New York.

(Photographer: Ted Russell)



One of the Sessions in the Waldorf Astoria Ballroom

Garson Meyer Re-elected to a Third Term as President of National Council on the Aging

DETROIT, MICH.—Garson Meyer of Rochester, N. Y., retired Eastman Kodak executive, was unanimously re-elected to a third term as president of the National Council On the Aging as the organization concluded its 15th annual meeting here.

Replacing Mrs. Walter W. Walker of Minneapolis as secretary of NCOA was Dr. Juanita Kreps of the Department of Economics, Duke University. Mrs. Walker asked to be replaced due to the press of commitments for the coming year.

Newly named to the Board of Directors of NCOA were 10 persons active in the field of developing programs for older people. They were:

Alexander Aldrich, of Chatham Center, Valatie, New York, Candidate for Congress, 28th District, New York; recently resigned as Executive Assistant to the Governor of New York.

The Honorable **Herman Badillo**, of New York City, Borough President of the Bronx.

The Honorable **Max Berking**, of Rye, New York, President of Max Berking, Inc., Advertising and Marketing; member of New York State Senate.

James E. Birren, Ph.D., of Los Angeles, California, Director of the Rossmoor-Cortese Institute for the Study of Aging, University of Southern California.

Robert G. Boucher, of Denver, Colorado, Senior Vice President, Mortgage Investments Company; Member Colorado Commission on the Aging and Chairman of its Committee on Non-Profit Housing.

The Right Reverend Monsignor Lawrence Corcoran, of Washington, D. C. Executive Director, National Conference of Catholic Charities.

Harold Gowing, of Portland, Oregon, Member of Oregon Inter-Agency Commission on Aging, Manager, Public Relations Department, Esco Corporation.

Lawrence O. Houstoun, Jr., of Washington, D. C., Principal Analyst, Planning, Evaluating & Programming Staff, Office of the Secretary of Agriculture.

The Honorable **George R. Metcalf**, of Auburn, New York, Publisher of the Auburn Citizen Advertiser; former member of New York State Senate.

Harold L. Sheppard, of Washington, D. C., Staff Social Scientist, W. E. Upjohn Institute for Employment Research.

The National Council On the Aging is a national, voluntary agency providing leadership services for organizations and individuals concerned with the field of aging. It is a non-profit, non-governmental organization that is supported by grants from foundations, contributions from individual companies and unions, and membership fees.

In Retrospect

A Brief Look at Progress In Public Health in the Past Calendar Year

The progress in health services provided during the past year has been heartening. Significant advances have been made in the major on-going programs sponsored by the N. C. State Board of Health in cooperation with the 61 local health departments which bring these services to every county.

In the first six months a total of nearly 14,000 children and others were beneficiaries of the Crippled Children's program. This program provides services in the following areas: flat foot; club foot and/or metatarsus varus; tibial torsion; rheumatic fever; congenital heart; cerebral palsy; polio, congenital bone and joint and cleft lip and/or palate, and others.

An estimated total of 665,000 laboratory specimens from physicians, health centers and State institutions have been analyzed this year by the Laboratory of the State Board of Health—an 11% increase in such requests over the previous year.

A most significant development in 1965 has been the implementation of the plan for neurological and sensory disease clinics. Two clinics are now in operation at Fayetteville and Greenville.

During the year, 13 nursing homes were licensed, making a total of 80. There are currently 10 homes under construction and 9 homes approved for construction. The licensed homes represent 3,481 nursing beds, and 1,480 resident beds, 723 beds are under construction and 522 beds are approved for construction.

During the past year an efficient progressive approach to metabolic screening has been developed and is being applied to newborn population. There has been marked progress in implementing the new contraceptive techniques and there are now 90+ counties active in the field.

This is the greatest year in the history of the Film Library. A total of 240 new films were purchased and 41,500 films were distributed to borrowers. These

borrowers represented individuals, schools, churches, clubs, fire departments, hospitals and many other sources of film need.

In Emergency Health Preparedness, the North Carolina State Board of Health has Medical Stockpile in the form of 50 Packaged Disaster Hospitals pre-positioned in 48 counties. North Carolina has reported 13,240 persons taking Medical Self-Help Training.

Nutritionists have been instrumental in initiating and carrying on educational programs in many counties with people who receive commodity foods or are in the food stamp program. They have also increased services in nutrition education to school food service personnel.

Two new programs, Migrant Health and the Training Task Force, were set up and put into full scale operation by the Local Health Division during the year 1965. The Migrant Project developed the **North Carolina Health Service Index**. This **Index**, together with those being developed in other Eastern Seaboard states, will facilitate referrals of migrant farm workers for health service continuity. A third project, Home Health Services, an important component of Medicare, is being organized to begin functioning January 1, 1966.

During the year, assistance was given local officials and approved construction of 58 new public water supplies. Assistance was given local health departments in identifying the vector and suppressing the encephalitis outbreak in eastern North Carolina during August. Drainage and dyking operations by 10 draglines working on salt marsh mosquito control materially affected the tourist public and health conditions in eastern North Carolina. Transfer by the General Assembly of shellfish sanitation activities will enable us to help this industry and better protect the health of the people. Agricultural labor camps reached a high degree of compliance with sanitation requirements. Assistance to the N. C. Department of Public Instruction through the survey of water and sewerage systems with recommendations will add to the improvement of health conditions in schools throughout the State.

In response to a joint invitation by the State Board of Health and the School of Public Health, the National Center for Health Statistics (USPHS) made commitments to move a portion of its Data Processing Division to the Research Triangle Park as soon as building space is available.

Beginning May 1, 1965, the Accident Prevention Section initiated a follow-up study of all deaths due to accidental drowning in North Carolina. This study will continue through April 30, 1966.

The Occupational Health Program showed a North Carolina dusty trades worker has only 1/20 as much chance now to develop disabling silicosis and have it diagnosed as he had just twenty years ago. There were 30 per cent more safe and beneficial uses of regulated radioactive materials than a year ago.

During 1965 the Tuberculosis Control Section conducted tuberculosis control activities in 27 county health departments. In addition, patients and inmates in several State institutions were examined.

Through a cooperative, intensive effort of health workers in North Carolina, the yearly rise in syphilis incidence witnessed since 1957 was halted in 1965.

The Immunization Activity Program is involved in a person-to-person visitation program to encourage early immunization of newborn children in North Carolina.

Reorganization of Public Health Service

Secretary of Health, Education and Welfare John W. Gardner, following President Johnson's Message to the Congress calling for reorganization of the Public Health Service, issued further details on the proposed plan as it applies to the internal organization of the Service.

Secretary Gardner stressed the need for future Secretaries of Health, Education and Welfare to have the power to reorganize the Service and its components as changing times may require.

"It is important, as the President points out in his message, that the Service be brought up to date. For the long run, any Secretary of Health, Education and Welfare should be able to provide the Surgeon General and his staff with the sort of organization which will best serve the health needs of the Nation. It is axiomatic that in a society such as ours, our institutions be continuously ready to make these necessary adaptations."

Secretary Gardner said that the plan envisions the establishment of five operating Bureaus plus the Office of the Surgeon General.

Under the five-Bureau plan, if the powers are granted to the Secretary, the following regroupings would take place:

The Office of the Surgeon General would include all the activities it now conducts, with the exception of the Division of Health Mobilization which would be located in the Bureau of Health Services. In addition, the Office of the Surgeon General would assume additional central responsibilities for management of grant and contract activities, processing statistical data for Service-wide use, programs in planning and analysis. International health, scientific and public communications, inter-

agency liaison and personnel would be strengthened. The National Library of Medicine and the National Center for Health Statistics remain as an integral part of the Office of the Surgeon General with the chiefs of these units reporting to him.

The Bureau of Health Services would be made up of the present Divisions of Medical Care Administration, Hospital and Medical Facilities (Hill-Burton), Indian Health, Hospitals, and Health Mobilization, plus the Bureau of Prisons, Peace Corps and the Coast Guard medical programs and portions of the Divisions of Community Health Services and Chronic Diseases.

The Bureau of Health Manpower would include the present Divisions of Dental Health and Nursing, plus those activities of the Divisions of Hospital and Medical Facilities and Community Health Services which relate to the development of health manpower.

The Bureau of Disease and Injury Prevention and Control would be made up of the Communicable Disease Center, the Arctic Health Research Center, the Offices of Pesticides and Solid Waste Disposal, and the Divisions of Accident Prevention, Environmental Engineering and Food Protection, Air Pollution, Occupational Health, Radiological Health, and Foreign Quarantine, plus the disease control programs of the Division of Chronic Diseases.

The National Institute of Mental Health would incorporate the present activities of the existing Institute plus the Public Health Service Hospitals for drug addiction at Lexington, Kentucky and Fort Worth, Texas; and would serve as the principal focus for research and control programs related to alcoholism.

The National Institutes of Health would remain a bureau of the Service in

parallel with the other bureaus described above. To the present structure of the Institutes would be added a National Institute of Environmental Health Sciences.

Under the present organization the Public Health Service consists of four Bureaus—Bureau of Medical Services, Bureau of State Services, National Institutes of Health and the Office of the Surgeon General which encompasses the National Center for Health Statistics, the National Library of Medicine, the Divisions of Health Mobilization, Public Health Methods, Finance, Administrative Services and Internal Audit, the Offices of Personnel, International Health, Information and Publications, and Equal Health Opportunity.

Are You A Defensive Driver?

Are you a defensive driver? Check out these questions below and see if you qualify:

- 1. Do you often make fast stops? The defensive driver seldom, if ever, has to "hit his brakes." He stays alert to the situation ahead and slows in advance. Quick stops indicate a failure to foresee trouble and plan to avoid it.
- 2. Do you have close calls at inter-

sections? The defensive driver doesn't. He approaches each intersection prepared to deal with sudden changes in the traffic pattern and unexpected actions by other drivers.

3. Do you have to brake on curves and when turning corners? The defensive driver doesn't. He eases up on his motor and slows before reaching the turn.

4. Do you have to "hit the brakes" when the driver ahead of you stops short? The defensive driver doesn't. He always stays far enough back so that he can slow down easily if the car ahead stops short.

5. Do you glide past cars that are stopped preparing to turn? The defensive driver doesn't. He passes with caution, aware that the stopped driver may change his mind, or that there may be a pedestrian in front of the stopped car.

6. Do you make fast starts? The defensive driver doesn't. He always starts easily so that he is prepared for a sudden change in circumstances.

Do you check out as a defensive driver? If not, it's time to review your present driving methods. If you don't you may be greatly increasing chances that you will be involved in a serious traffic accident.

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Hospitals Are Being Certified to Become Eligible to Participate in Medicare

Surgeon General William H. Stewart of the Public Health Service reported today that, as of April 20, 4932 or 58% of the Nation's 8550 hospitals have been certified to the Social Security Administration as complying with Title VI of the Civil Rights Act and are, therefore, eligible to participate in the Medicare Program which begins July 1.

The 1805 hospitals which have not as yet returned the **Medical Facilities Compliance Report** have been mailed another copy of the Report and urged to return it promptly. Reports now being returned as a result of the second mailing are still in process of review and evaluation. Those hospitals which

do not return a **Medical Facilities Compliance Report** together with those which continue to be in non-compliance face cut-off of all present Federal assistance and denial of all future participation in any Federal program.

The Surgeon General stressed the responsibility of each hospital to its patients and its community to bring itself into compliance with Title VI.

"With respect to Medicare," Dr. Stewart said, "the Federal Government will pay the bill. But the Federal Government can pay for care only when the hospital is in compliance with the law of the land. It becomes, therefore, not only the obligation of every hospital to comply but of every community to assure itself that its hospitals are in compliance with Title VI to guarantee that its elderly citizens will receive the medical care to which they are entitled under Medicare. And beyond the Medicare Program, each hospital faces cut-off of all Federal assistance if it continues to discriminate."

Miss Jane Wentworth of Asheville, Nutrition Consultant with the State Board of Health, has been named Chairman of a special committee of the Nutrition Section. This committee seeks to develop educational materials on diet for use with blind diabetics.

In the picture, studying these materials, are, from the left—Mrs. Mary Ann Farthing, Assistant Chief of the Nutrition Section, Sallie J. Mooring, Consulting Dietitian, Jane Wentworth, Nutrition Consultant, Anne Davis, Nutrition Intern, Mrs. Helen H. Jackson, Nurse with the Commission for the Blind, Charlotte, N. C., Mrs. Mabel G. Rogers, Nutrition Consultant.



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DATES AND EVENTS

May

- 9-11—American National Red Cross, San Diego.
- 12-13—Western District NCPHA, Fontana Village.
- 12-14—N. C. Motel Association Convention, 13th Annual, Greensboro.
- 15-18—N. C. Federation of Women's Clubs Convention, 64th Annual Pinehurst.
- 16-20—American Industrial Hygiene Conference, Pittsburgh.
- 16-20—Southern Branch APHA, Shamrock Hilton Hotel, Houston.
- 18-20—N. C. Hospital Health Convention, Winston-Salem.
- 20-21—N. C. Senior Citizens Conference, Winston-Salem.
- 22-25—National Tuberculosis Association/American Thoracic Society/National Conference of Tuberculosis Workers, San Francisco.
- 29-June 3—National Conference on Social Welfare, Annual Meeting, Chicago, Ill.

* * *

Joyce Kilmer Memorial Forest is one of the most impressive remnants of our Nation's virgin wilderness. Located in western North Carolina not far from

Fontana Village Resort, immense trees grow in the natural setting that was theirs when this region was the unexplored hunting ground of the Cherokees.

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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Jacob Koomen, M.D., M.P.H.
North Carolina's State Health Director



W. Burns Jones, M.D., M.P.H., Becomes Assistant State Health Director

Dr. W. Burns Jones became Assistant State Health Director on May 4, 1966 by the unanimous action of the State Board of Health with the approval of Governor Dan K. Moore. He had been serving as Acting Assistant State Health Director since January 1, 1966 when Dr. Koomen, then the Assistant State Health Director, was named Acting State Health Director.

A native of Eufala, Alabama, Dr. Jones was graduated from THE CITADEL and earned the M.D. degree from the Medical College of South Carolina. Later he received the M.P.H. from the School of Public Health of the University of North Carolina at Chapel Hill. He was a member of the Army Reserve 1951-58.

Dr. Jones is licensed to practice medicine in South Carolina, the Territory of Alaska and in North Carolina.

For three years after his medical training, Dr. Jones served as a Medical Missionary and Administrator of a hospital in Alaska. In 1960 he began a two year term as Local Health Director in Warren County, North Carolina. Later Franklin County was added in this district.

In November of 1962 Dr. Jones came to the State Board of Health, serving as Assistant Director of the Local Health Division and then as Assistant Chief of the Chronic Disease Section.

On leave of absence from November 1964 to January 1965, Dr. Jones served in a special assignment as a Consultant to the North Carolina Fund. During this period and until December 1965 he was Director of the Local Health Division. From this position he became Acting Assistant State Health Director and on May 4, 1966 the Assistant State Health Director.

Dr. Jones is a member of the following professional societies: American Medical Association, Medical Society of the State of North Carolina, Wake County Medical Society, American Public Health Association, North Carolina Public Health Association, Royal Society of Health, Delta Omega, The Honorary Public Health Society.

Dr. and Mrs. Jones have three children and live at 745 Powell Drive, Raleigh.

One of the most popular forms of recreation at Fontana Village Resort, located in the heart of the Great Smoky Mountains of western North Carolina, is square dancing. During the summer season, three dances are held each week in the main Recreation Hall, with an average attendance of more than 500 dancers and spectators. The resort has its own staff musicians, the Fontana Ramblers, who provide toe-tapping music for visitors to the friendly family vacation village.

Jacob Koomen, M.D., M.P.H.

North Carolina's State Health Director

Dr. Jacob Koomen became North Carolina's sixth full-time State Health Director on May 4, 1966 by the unanimous action of the State Board of Health with the approval of Governor Dan K. Moore.

Dr. Jacob Koomen had become Acting Director of the State Board of Health, January 1, 1966. He was named to this position to complete the remaining year and a half of the term of Dr. J. W. R. Norton, who resigned this position for health reasons after a seventeen and a half years' term of service.

A native of Bristol, New York, Dr. Koomen was graduated from the University of Rochester School of Medicine and completed residency training in Internal Medicine in this institution. Following this, he became Instructor in Medicine and Bacteriology and Assistant Physician in the same institution and in its teaching hospital, Strong Memorial, for a five year term of service. He also served as Associate Director of the Rochester Health Bureau Laboratories.

In 1954, Dr. Koomen was assigned to the North Carolina State Board of Health by the Epidemic Intelligence Service of the U. S. Public Health Service. At that time he held the rank of Surgeon. After two years in this position, he became Assistant Director of Epidemiology for the State Board of Health. In 1957, Dr. Koomen received his Master of Public Health Degree from the University of North Carolina School of Public Health at Chapel Hill.

For the four year period beginning in 1961, Dr. Koomen served as Assistant State Health Director. On January 1, 1966, he came to his present position as Acting State Health Director.

Dr. Koomen has been active in many public health activities. He was the recipient of the Reynolds Award given by the North Carolina Public Health Association in 1960, for outstanding contributions in public health in North Carolina. He holds membership in the American Medical Association, the American Public Health Association, the Conference of State and Territorial Epidemiologists (President, 1965), the North Carolina State Medical Society, the North Carolina Tuberculosis Association (Director), the North Carolina Public Health Association, the Southern Branch, A.P.H.A., the Wake County Medical Society, the Raleigh Academy of Medicine, and the North Carolina Legislative Council (President, 1965).

Dr. Koomen is the author or co-author of a number of publications in the field of Epidemiology. He holds the rank of Senior Surgeon (R) in the U. S. Public Health Service. He is currently Visiting Associate Professor at the University of North Carolina School of Public Health.

Dr. and Mrs. Koomen have four children, two boys and two girls, and live at 909 Dogwood Lane, Raleigh, North Carolina.

North Carolina's Distinguished Roster of State Health Directors

The election of Dr. Jacob Koomen as Secretary-Treasurer and State Health Director naturally turns the spotlight on the distinguished roster of medical doctors who served in this position, either part-time as the first two served, or full-time from 1909 on. The position was called State Health Officer until it was changed to State Health Director during Dr. Norton's administration.

Here is the full list with the dates of their service:

- Dr. Thomas F. Wood, 1877-1892 (part-time)
Dr. Richard H. Lewis, 1892-1909 (part-time)
Dr. W. S. Rankin, 1909-1925 (All served full-time from 1909)
Dr. Chas. O'H. Laughinghouse, 1926-1930
Dr. James M. Parrott, July 1, 1931 - November 7, 1934
Dr. Carl V. Reynolds, November 10, 1934 - June 30, 1948
Dr. J. W. R. Norton, July 1, 1948 - December 31, 1965
Dr. Jacob Koomen, January 1, 1966 -
-

From early spring until the leaves fall in November, Fontana Village Resort is a nature lover's paradise. It is situated on the southern edge of the Great Smoky Mountains National Park, and nestles between the Park and the 449,000-acre Nantahala National Forest.

Completely forested, the area contains some of the most impressive remnants of our Nation's virgin wilderness. Countless varieties of flowers, shrubs and trees can be found by the serious student, and even for the casual hiker there is an ever-changing series of beautiful woodlands or overlooks with breathtaking scenery.

Competent Hands

North Carolina's public health system has been put in competent and careful hands with the naming of Dr. Jacob Koomen Jr. as State Health Director. This move on the part of the State Board of Health was expected not merely because Doctor Koomen has served as Acting Director since the first of the year, but because he stood eminently qualified, both in professional ability and in personal character.

There is not always public awareness of the high caliber of many who serve this state in high positions of state government. As North Carolinians come to know Jacob Koomen better in the years ahead, that awareness will increase.

—Raleigh News & Observer

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May, 1966

No. 5



John W. Knutson, D.D.S., Dr. P. H. (right) is shown with Dr. E. A. Pearson, Jr., Director of the Dental Health Division of the N. C. State Board of Health, as these leaders conferred recently in New York during the National Health Forum. Dr. Knutson is the newly elected president of the National Health Council and is Professor of Preventive Dentistry and Public Health, University of California, Los Angeles.

The Time For Action

"The chaotic conditions of lack of health planning and of effective health administration" are seriously hampering the nation's fight against disease and other hazards to health, according to Dr. John W. Knutson, incoming president of the National Health Council.

"Anarchy in health administration is common throughout the land," Dr. Knutson told the opening session of the 14th Annual National Health Forum. More than 600 leaders in the fields of medicine, law, business, education, health and city planning attended the

Forum. Dr. Knutson is professor of preventive dentistry and public health at the University of California at Los Angeles Medical Center.

The National Health Forum this year devoted its sessions to analyzing the report "Health is a Community Affair," the result of a two and a half year study conducted by the National Commission on Community Health Services, financially supported by private and public funds. The report was presented to President Johnson recently.

Dr. Knutson said the drafters of the report found that to achieve full use



Forum participants, from the left: C. F. McNeil, Director, National Social Welfare Assembly; Margaret Dolan, Professor of Public Health Nursing, UNC School of Public Health; and Lyman Ford, Executive Director, United Community Funds and Councils of America.

of available health resources in the United States, "We are desperately in need of the managerial skills required to bring fusion to an operation which is now characterized by fission, splintering, anarchy and chaos."

In addition, he said, lack of coordination of health services has resulted in a situation where "a good share of the promises of health research over the past several decades is not being kept."

Dr. Knutson said the Public Health Service "has estimated that failure to use new research findings is responsible each year for 40,000 deaths from cancer, 20,000 deaths from rheumatic heart diseases, and for the needless suffering of millions of persons from other ailments."

Americans tend to see themselves as having the highest standards of community health on earth, Dr. Knutson told the National Health Council.

"On the other hand, American communities are beginning to accept the fact of possible community disaster," Dr. Knutson said, "There is the threat—only dimly perceived in many quarters—of disastrous health hazards arising from the tensions and frustrations of swarms of people surging into towns and cities, initially unplanned and already full to bursting, and attempting to live there and maintain their accus-

tomed freedoms, their divergent cultural patterns, and their conflicting value systems."

Too many Americans think of health in the limited sense of prevention and cure of communicable diseases, Dr. Knutson suggested, but there is much more to the problem of attaining adequate community health. For example, he said, mental illness is a hazard of great, if unknown, dimension, and "none of us can escape the feeling that it is increasing alarmingly."

Forum Leaders, from the left: Peter G. Meek, Executive Director, National Health Council; George James, M.D., President, National Health Council; and Berwyn F. Mattison, M.D., Executive Director, American Public Health Association. The Council and the APHA were co-sponsors of the National Commission on Community Health Services.



Health Is A Community Affair

Four-year study of the nation's Community health services and problems is considered at the National Health Forum held in New York in May

Brief excerpts from the 300 page report setting forth fourteen major positions are presented here.

PRESIDENT Johnson accepted recently for the people of the United States a Report called **Health is a Community Affair**. Marion B. Folsom, chairman of a private organization that has just completed a four-year study of the nation's community health services and problems, presented the report, stating his wish that **this affair** "may prosper in communities all over the land."

Mr. Folsom said that "every resident of the nation, whether he lives in New York City, the West Virginia hills, the bayous of Louisiana, or the plains, mountain or coastal areas of the country, should be able to learn about and attain those health services needful to himself, his family and his neighbors."

The report was prepared by the National Commission on Community Health Services whose sponsors are The American Public Health Association and the National Health Council. The Commission was organized in 1962 and will

(Continued on page 11)



Marion B. Folsom



Pictured from the left, across the top: Jacob Koomen, M.D., N. C. State Health Director, with Berwyn F. Matison, M.D., Executive Director, American Public Health Association; H. P. Hopkins, Ph.D., Nashville, Tenn., newly elected president of Southern Branch, APHA; Ernest L. Stebbins, M.D., president of the American Public Health Association; Elizabeth S. Holley, a past president of Southern Branch, with Fred W. Hering, Executive Secretary, Southern Branch, and Mrs. H. P. Hopkins.



So
American
Holds successful Annual S



Left column — bottom two pictures: Margaret Hambright, Goldsboro, N. C. Nutrition Consultant, with Elizabeth Jukes, Chief of N. C. Nutrition Section; and Robert Brown, Asheville, president NCPHA, with Helen Hunt, Regional Health Office, Sommerset, Ky. Right column—bottom two pictures: two local health Directors, Dr. Maurice Kamp, Charlotte, and Dr. Ben Drake, Gastonia, with A. Clark Slaymaker, Alexandria, Va., Director of Environmental Health; and an informal pose of Dr. Mattison and Dr. Koomen.



...n of the
...eth Association
...mrock Hilton in Houston, Texas.



Candid Shots from Southern Branch APHA



Peter G. Meek, (center) Executive Director, National Health Council, in informal conference at the National Health Forum with Marion B. Folsom (right) chairman of the National Commission on Community Health Services, and Richard Schlesinger, Associate Director of the National Commission.



Health, a Community Affair

(Continued from page 7)

terminate its activities at the end of August, 1966, when its studies have been published.

The Commission takes fourteen positions in its report. It considers them to be major issues in health services today and discusses them with their supporting recommendations. A short statement of positions and related recommendations follows:

Community of Solution: The organization and delivery of community health services by both official and voluntary agencies must be based on the concept of a community of solution, rather than primarily on political jurisdictions.

Health service administrative areas cannot be circumscribed by traditional political boundaries. The health service boundaries of the community are established by the area within which a problem can be defined, dealt with, and solved.

In order to establish health service boundaries, the Commission recom-

mends that each state organize a Health Policy and Planning Commission to examine, with the State Health Department, the state's present pattern of health jurisdictions and recommend regional configurations of political units conforming to problem-sheds or health marketing areas. Appropriate use must be made of compacts, agreements, interstate authorities and other procedures for expediting delivery of health services. Boundaries of the regions so established would be regularly assessed and revised for continuous adaptation to the changing dimensions of health problems.

Comprehensive personal health services: Communities must take the action necessary to provide comprehensive health services of high quality to all their citizens. These services would include promotion of positive good health by application of early detection of disease, prompt and effective treatment, and physical, social, and vocational rehabilitation of those with residual disabilities.



Miss Mary Hayes, at the National Health Forum, charms there and in her work in West Virginia even as she did while a health educator in North Carolina.

This action would assure both availability and accessibility to all age groups. Among the services recommended are: health education, family planning, environmental services, prevention of disease and disability, school health and nutritional services, early diagnosis and treatment with systematic follow-up.

The Personal Physician: Every individual should have a personal physician to provide a continuity of integrated medical and medically related services.

The personal physician must have a broader knowledge of the elements of comprehensive health services than medical students now receive. The American Medical Association and the Association of Medical Colleges should take the initiative in developing specific recommendations for the education of the personal physician. This education should emphasize preventive medicine, internal medicine, pediatrics, psychiatry and rehabilitation.

The personal physician will provide the services needed or direct his patient to whatever services best suit his needs. He will maintain such relationship with other physicians and care facilities that will assure his patient twenty-four hour, seven-day-a-week medical services.

ty-four hour, seven-day-a-week medical services.

The Environment: Man can and must so manage his environment as to stimulate healthful growth, even though presently he is contaminating that environment at a rate fast approaching saturation. Moreover, people are using biological and chemical products indiscriminately, unaware for the most part, of their hazards. The need for citizen action is urgent.

Improving the quality of our environment requires additional financial resources public and private, adequately planned and programmed to assure the control of water and air pollution and protective measures against contamination from biological and chemical products, including the use of radioactive materials.

There should be a nationwide, continuous, automated air sampling network that includes every potential or known source of air pollution, whether biological, chemical or radiological. Government and industrial funds must be provided in vastly increased amounts to assist in developing controls, but prevention and elimination of sources of pollution must proceed on the basis of present knowledge.



Fontana Village — An Enjoyable Vacation Spot

Accident Prevention: Accident prevention is an integral part of comprehensive health service. Health leadership must increase its efforts to prevent accidental injuries, disabilities and death.

State health departments should take the initiative in developing statewide accident prevention programs, with the cooperation and support of other official and voluntary agencies. The Public Health Service should be given funds to establish a national accident prevention research and training service and information facility comparable to the present Public Health Service Communicable Disease Center in Atlanta, Georgia.

Family Planning: Both public and private health agencies should provide family planning services and research in human fertility.

Research in human fertility and related factors influencing population change must be intensified, and instruction in family planning must become a routine health service carried out in appropriate facilities by qualified personnel.

Urban Design and Health: Those who control use of the land, transportation, and economic development must assume responsibility to plan for more effective use of space and for reduction of the emotional and physical hazards of high population density.

Appropriate federal departments should initiate cooperation with voluntary and professional organizations to develop criteria for measuring the effects of population mobility and density on the health of people and to promote research and experimentation in population distribution. Model legislation should be developed to require city planners to include in their planning goals, healthful distribution of population, protection from density hazards, elimination of noisy and unaes-

thetic environments.

Education for Health: Both the community and the citizen have their responsibilities. The community is responsible for informing and motivating its citizenry to utilize health services, at the same time avoiding quackery. The citizen is responsible for making use of available services according to his needs.

State departments of education and local school boards should provide health curricula which assure continuity of health instruction throughout the entire school experience.

Health departments and voluntary health agencies should make available to business and industry supplemental education services for in-plant health information and counseling. These services should draw freely from social science research findings.

Health Manpower: To provide comprehensive health services in the coming decade will require intensive, planned and continuous efforts to recruit, educate and train manpower for the health team.

Each community must have access to the skills and techniques of many kinds of health personnel. The needs for these skills and techniques are increasing. Among them are nurses, physical and occupational therapists, homemakers, health aides, social workers, psychological vocational counselors, nutritionists, various kinds of laboratory technicians, and many others.

The Public Health Service should assume responsibility for collecting and reporting health manpower data on a nationwide basis, using standardized classifications as developed in cooperation with other health agencies. In order to attract and retain health personnel at all levels, wages and salaries should be made comparable with those received by people performing similar jobs in the community. Wage and hour

laws and other protective legislation should be amended to include health personnel, wherever their place of employment.

Hospital Costs and Care: Further increases in hospital costs must not be accepted complacently. Vigorous and persistent action must be taken by all parties concerned to moderate the costs of hospital care without adverse effects on its quality.

A high priority should be given to the development, in the hospital or affiliated with the hospital, of extended care facilities, self-care units, rehabilitation units, home care programs, day centers for old people, foster family programs, and a network of alternative outpatient services to encourage appropriate utilization of facilities.

Official State Health Agency: Every state should have a single, official health agency with sufficient authority and funds to carry out its responsibilities, one of which would be to assure access of the complete range of health services to all communities in the state.

The state health agency should stimulate development of local health units. These may be responsible for a city or

county or a city-county or several counties combined, depending on the configuration which can best serve the people effectively. The local unit should carry out duties delegated by the state and others which are locally determined. The local health unit should be adequately financed and staffed with full-time personnel who have been especially trained in community health services.

The Volunteers: The American tradition of voluntary citizen participation must be extended to develop and guide community health services.

Collaboration in health matters among voluntary agencies, governmental and private elements should be strengthened at local, state and national levels. Voluntary participation of individuals and groups is a primary means of utilizing the full resources of the community to plan for and carry through community health services. Present efforts to extend voluntary participation should be examined, evaluated and strengthened by agencies both separately and jointly.

All states should enact and enforce legislation to control solicitation of funds from the public for charitable purposes.

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Action-Planning: Planning is an action process and is basic to development and maintenance of quality community health services.

Action-planning for health should be community wide in area, continuous in nature, comprehensive in scope, all-inclusive in design, coordinative in function, and adequately staffed.

Each community should develop and maintain an action-planning mechanism for health services.

Each community should develop a coordinated health education and communication system.

Schools of social work, public health, hospital administration, and graduate schools of social and political science and public administration should initiate or expand health planning courses to provide opportunities for public health personnel, social welfare personnel and hospital planners to be trained together with the broadest possible professional orientation and community wide perspective. Schools of public health, social work, hospital administration, and public administration, should develop a core curriculum for training health planners. Each com-

munity should develop capabilities for collecting, analyzing and using data for action-planning with the cooperation and assistance of appropriate state or regional groups.

The Commission's Report was the basis for discussions at the National Health Forum, in New York. Some six hundred individuals involved with community planning for health services were invited to consider and discuss how the Commission's recommendations can be implemented.

The Commission's publications will include, in addition to its Report, the reports of six task forces, four community studies and a Community Planning Guide. It is anticipated that the entire series will be published by the Harvard University Press.

The major financial contributors to the Commission are the W. K. Kellogg Foundation, the Commonwealth Fund, the Public Health Service, the Vocational Rehabilitation Administration, the McGregor Fund, and the New York Foundation. Other contributions were received from business and industry, and each of the twenty-one Community Studies was supported locally, either financially or with personnel or both.

Panelist Reactors during a session of the National Health Forum in New York. From the left: Robert F. Young, M.D., Health Director, Halifax County, N. C.; Richard K. Bernstein, New York, Executive Director, City Planning Commission; and Gaylord W. Anderson, M.D., University of Minnesota School of Public Health.



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DATES AND EVENTS

- June 19-24—American Society of Medical Technologists, Los Angeles, Calif.
June 20-24—Air Pollution Control Association, San Francisco, Calif.
June 24-25 — American Geriatrics Society, Chicago, Ill.
June 26-30—American Medical Association (Annual), Chicago, Ill.
June 26- - July 1 — American Physical Therapy Association, Los Angeles, Calif.
June 26 - July 2—International Congress of Gerontology, Vienna
June 27-30 — International Food Congress, Copenhagen
July 7-9 — American Medical Women's Association, Rochester, N. Y.
July 9-15—American Veterinary Medical Association, Louisville, Ky.
July 10-17—International Dental Federation, Tel Aviv
July 18-22 — International Congress of Occupational Therapists, London
August 3-10—International Congress on Nutrition, Hamburg
August 29 - Sept. 1—American Hospital Association, Chicago, Ill.

- September 4-10 — International Conference of Social Welfare, Washington, D. C.
September 5-7 — International Conference on Water Pollution Research, Munich

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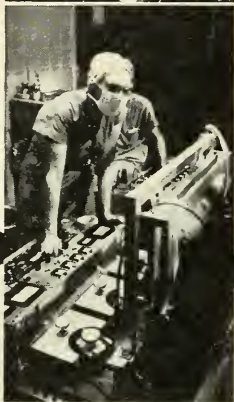
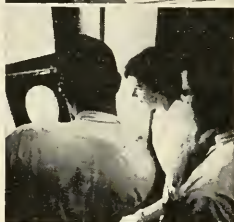
The REAL Health Care Question

"Whether we should organize for prevention and early detection, and how we should set up and finance such services, will increasingly be the real health-care question. We have today provided for the financing of the kind of health care that gave medicine its traditional name: "the healing art." But medicine is becoming more and more capable of being also "the health-giving art." And growing numbers of physicians, public-health people and hospital administrators are coming to believe that to confine our health-care finance to paying for repair work is shortsighted, both medically and economically."

Excerpt from article entitled "Medical Costs: Away They Go" which begins on pages 2 and 3.

81, #6

June 1966



Medical Costs: Away They Go

by Peter F. Drucker

America's medical bills are high, and going higher. In this perceptive study, a well-known management consultant shows where the billions go, what they buy—and what they ought to buy.

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EVERYBODY knows that medical-care costs are rising sky-high. And "everybody" is quite right. The total health-care bill of the United States in 1965 came to \$37 billion—10 times what it was in 1929, and three times what it was in 1949. Next to defense and education, health care has become the most expensive service the American public buys. Yet, what "everybody knows" is also quite misleading.

The fact is that health care took about four cents out of every dollar the American public spent in 1929 and today it takes 5½ cents. But most of that increase took place before 1950, and most of it is public rather than private spending. If measured against the "disposable income" of the consumer (that is, income left after taxes), health-care costs take about the same slice out of a family budget that they took way back in 1929, or in 1946.

Furthermore, to compare the health care of 20 or 40 years ago with the health care of today is like comparing a bowl of chili at the automat to a steak-and-champagne dinner at "21." There has been a radical shift in our demands and expectations: **We now expect everyone in this country to receive the standard of health care which a few decades ago only the well-to-do could afford.**

The deciding factor in health-care spending in the past was income; now it is insurance.

Forty years ago, when the first comprehensive study of medical-care costs was made in this country, it was found that the lower income groups used health-care services less than half as much as the well-to-do. Today the insured, whatever their incomes, use health-care services about as intensively as did the well-to-do of an earlier generation. Forty years ago, no more than one quarter of the population—30 million people at most—had the income

to pay for the full health-care services then available. One hundred and fifty-five million Americans now carry voluntary insurance against hospital costs. Practically all these people are also insured to some extent against surgeon's and doctor's bills. As a result, the market for full health-care services in this country is about five times what it was 40 years ago.

There are only about 180,000 practicing physicians in the United States today, not a great many more than in 1929. Yet, despite public complaints, there is no real shortage. For one thing the virtual abolition of the house call has practically doubled the number of patients a doctor can take care of. More important, there are now close to three million other people providing health service, half of them in the hospitals, one third in the pharmaceutical and medical supply industries, one sixth in the community, e.g., retail pharmacists or visiting nurses. These people, other than a smaller number of nurses and pharmacists, were unknown 40 years ago.

Only a fraction of today's health service workers are doing unskilled or semiskilled work, either as workers in the hospitals or in pharmaceutical plants. The great majority belong to what hospital administrators (and the U. S. Census) call "the paramedical professions": nurses, of course (still the largest group), but also physicists, chemists and biologists, pharmacists, social workers, psychologists, psychiatric case workers, physical therapists and dietitians, computer experts and all kinds of engineers, lab and X-ray technicians and administrators—practically all unknown in the '20s. Even without the employees of the pharmaceutical and medical supply industries, health service is already our second-largest occupational group, topped only by teachers. The physician of 1929 was largely

a "do-it-yourselfer." The physician of 1966 is primarily the "conductor" of a team.

Dramatic Impact

The shift of health care to the hospital has had dramatic impact on health-care economics. The non-profit community hospital was, 50 years ago, largely a charity institution for the dying poor. Forty years ago, almost all American babies were born at home. As late as 1939, four out of five bronchial pneumonia patients were looked after at home. Today, 98 percent of the babies are born in the hospital. And a bronchial pneumonia patient is promptly whisked to the hospital. Today's hospital dispenses almost half of all prescribed medicines. Including out-patients, the hospital takes care of five times as many patients and their health

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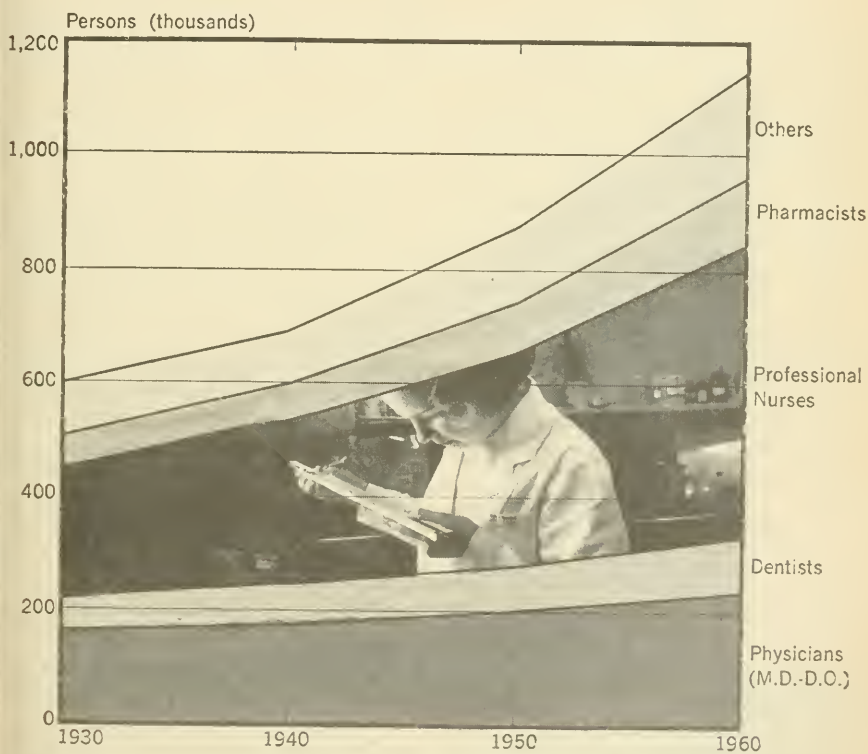
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problems as a hospital of similar size did in 1929.

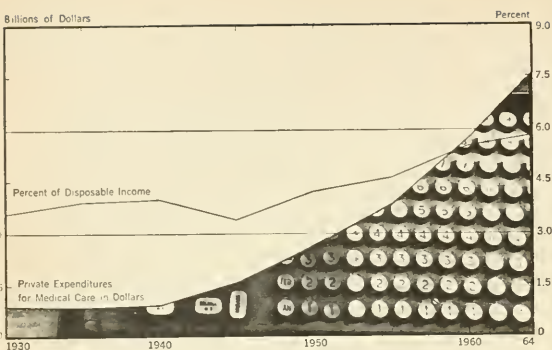
This hospital is often in the same pre-World War I building. But inside it is as different from the hospital of 1929 as a jet is from a World War I biplane. In 1929, a 250-bed hospital could be built for half a million dollars—\$2,000 or so per bed. Today, it could barely be built for 12 times that amount. A generation ago, many perfectly adequate hospitals had no X-ray machine, and few could run the simplest biological test beyond urinalysis.

The community hospital of 1929, or for that matter 1949, needed no more employees than it had patients. At least half of these did housekeeping work. Today's general hospital employs around 250 people for every 100 patients—proportionately twice as many as a luxury hotel. The great majority of these employees—three out of four—are professionals and technicians.

In the '30s, the typical general hospital spent less than \$10 to take care of a patient for one day, and the "hotel service" (food and housekeeping) took



There are now more than 200,000 physicians in the U.S., but only 180,000 of these are in practice, not many more than in 1930. The increased demand for health care, the author says, is being met by other professionals—nurses (still the largest group), chemists, biologists, social workers, psychologists, physicists and physical therapists.



Private spending for medical care in the United States rose sharply from the '40s to the '60s, but the health-care slice out of a family budget (percent of disposable income) did not show a comparable increase during the same period. Public spending also rose during the period and it would add another \$12 billion to the \$25 billion shown above.

half of that. Today, a patient-day in the general hospital costs \$42, with hotel service accounting for at most one fourth. In metropolitan areas the figure is well above \$50 a patient-day.

Yet the switch to the hospital and to the paramedical professions as the center of health care was probably the most economical way to take care of the enormous expansion of health-care demand. We had to multiply the effectiveness of the individual doctor, and that meant expanding the hospital and building health-service staffs. The same development has taken place in all Western countries, by the way. In Great Britain, for instance, hospital costs have risen even faster than in this country.

Historical Accident

It was largely historical accident that the United States (and it alone) built health-care finance on insurance against hospital expenses. But if Blue Cross had not been available, Americans would have been forced, in the last 30 years, to nationalize the community hospital.

When the hospital became the center of modern health care, its costs went up beyond anything the traditional sources of revenue could support. Charitable donations supplied a large part of operating costs 30 years ago. In dollars they are much larger today. Yet they are a negligible factor in the

community hospital's operating budget (donations still play an important role in capital budgets). The main sources of revenue are "third-party payments"—Blue Cross and private insurance companies. In industrial areas—Cleveland, for example—these supply 80 or 90 percent of hospital income.

Because our health-care finance started out with Blue Cross, it highlights hospital bills. Everybody, therefore, pays attention to the one area in health care where costs are going up faster than prices and incomes. It is hospital costs that labor leaders and employers are most concerned with, for hospitalization insurance has become a routine part of the bargaining "package." It is hospital costs that politicians and government officials note, for hospital insurance rates have to be approved by state governments. Above all, hospital costs are what employees are reminded of with every paycheck. And there is no getting away from the fact that hospital expenses have been going up fast, very fast: they double every nine years or so.

We have bought something with our money. The United States has all but reached the goal of making available to every citizen the level of health care only the really well-to-do could afford a generation ago. Medicare will be another step toward this goal.

When it becomes effective this year, Medicare will finance medical and hospital care for the two groups in the population, 35 million people in all, least able to pay: the aged and the poor on relief (the Medicare Bill calls them the "medically indigent"). These two groups have much higher needs for health care than the employed adults, and will use the new facilities very much more intensely than their numbers would indicate.

The old, largely because of the great incidence of chronic diseases among them, may need three times as many visits to the doctor or days in the hospital as young or even middle-aged adults. The very poor, if only because there are so many children among them, will also use health services disproportionately heavily.

Medicare will therefore cost a good deal more than the numbers covered—one sixth of the U. S. population or so—would imply. But how much it will cost is anybody's guess. No one, for instance, can estimate how much we will have to pay for the 100 days of nursing home care a year made available to the elderly sick under Medicare. No one knows because the nursing homes to give this care do not yet exist. The only thing certain is that Medicare will come high: \$10 billion a year would be a conservative mini-

mum.

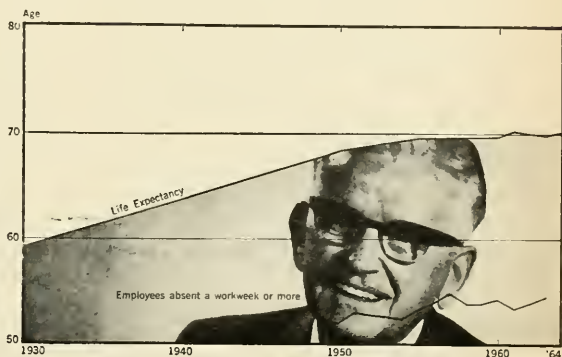
We do not, however, pay for Medicare directly as health-care customers. We pay for it through Social Security and higher taxes. Indeed, Medicare may temper, though briefly, the rise in individual hospital bills. Today, Blue Cross and insurance rates contain a hidden subsidy toward the hospital costs of the aged and of the medically indigent. Cities and states pay, as a rule, a good deal less for such patients than they cost the hospital. Tomorrow, Medicare will shoulder some of this expense.

Overdue Bill

Yet Blue Cross rates and premiums for private health insurance will still go up. One big bill for the new health-care standards and for the shift of health care into the hospital and its paramedical professions is outstanding—and overdue. It is the bill for wages.

Considering that the great majority of health-service workers are technicians and professionals, their wages are appallingly low. The average annual wage cost of a health service worker in the hospital (including fringe benefits) runs around \$4,000 as against a payroll cost of \$7,000 or more for factory workers and \$6,500 for schoolteachers. Health-care employees are the largest, grossly underpaid occupational group

Americans are living 10 years longer than they did just a quarter-century ago, but sickness—mostly minor stomach upsets and colds — continues at about same pace. The next big medical step, then, should be prevention; keeping the healthy healthy.



left in America. They are also in very short supply.

The pressures for equitable pay for health-service employees is rising. In New York and other big cities the poorest-paid of these workers—maids, janitors and orderlies—are increasingly represented by militant unions. But even some doctors on the hospital payroll are organizing for better pay. Five hundred interns and residents of the Los Angeles county hospitals staged a "heal-in" last year (half sit-down strike, half slow-down) and obtained a 10 percent pay raise. But the new pay scale pays a resident, who is a full-fledged M.D. with at least one year of hospital internship behind him, still no more than \$5,000 a year.

With Medicare coming in, the demand for health-service people will again increase. As a result, health-service salaries will fast rise to prevailing income levels; and payroll is the main (more than two thirds of) hospital cost. To raise health-service incomes from the present average of \$4,000 a year to the schoolteacher's pay of \$6,500 will raise the cost of one patient-day in the hospital from the current level of \$42 to \$60 or so.

Within the next two years or so, we may therefore see something like another 50 percent boost in Blue Cross rates and health insurance premiums. Whether we want to pay this or not is no longer a question. How we pay it will be the only choice we have, whether through the insurance premiums of individual consumers or through massive government subsidy. And this choice will probably determine whether the autonomous local community hospital survives the next decade, or is taken over by the government.

A great deal will therefore depend on economic conditions in the next few years. If incomes and employment are high, we will, I suspect, manage to pay

decent wages for health-service people without too much resort to government—though not without a good deal of grumbling.

Abuses and Safeguards

Is there no way, then, of stemming the rising tide of hospital costs, of cutting waste, abuse, inefficiency, or at least of offsetting these costs by cutting other health-care expenses?

One hears of a great many "abuses"—sensational stories, very often, such as reports of a surgeon who has relieved hundreds of women of their perfectly healthy wombs. There is undoubtedly a lot of poor medicine around, and it is exceedingly wasteful. But every study of medical and hospital care has come up with the same conclusion as the most thorough and most authoritative survey, **Hospital and Medical Economics**, conducted by the University of Michigan in 1958: "Bizarre cases of abuse are rare and probably non-existent . . . (Their) effect on total hospital use or on pre-payment or on insurance is trivial."

In fact, the American accredited hospital—which means practically every general hospital any one of us is likely to come in contact with—has imposed on itself safeguards against abuses: the tissue committee to police surgery; the medical-audit (or medical-records) committee to police the care given by doctors in the hospital; and, a brand new control, the utilization committee to supervise both admissions and length of stay in the hospital. All these, as committees of the medical staff, are organs of self-control.

What "abuses" might exist are therefore both much subtler and more difficult to get rid of.

Yet in any economic activity that has grown very fast there is always room for doing things better and more efficiently, for controlling costs, for cutting out waste. Health care is

certainly no exception. This is a very slow process in every industry, but in health care it is not just an economic process. It would require changes in professional relations and in basic community attitudes and values which few people are, or should be willing to make just for economic reasons. Without these changes the possibilities for savings are small indeed.

Drugs are a good example, if only because there has been so much talk of "exorbitant prices" and "exorbitant profits" in the drug industry. An economist tends to be somewhat skeptical about such talk. Drugs take today the same share of the health-care dollar they took 40 years ago. Prices and profits in the drug industry, moreover, look exactly the way prices and profits always look in an industry that has had explosive growth after a major technological breakthrough. In every such industry the growth very soon produces its own antidote in the form of vigorous competition. But even if drug profits were truly "exorbitant," eliminating them completely would cut the health-care bill at most by two cents on the dollar.

Hospital building and hospital spending on expensive equipment and hospital utilization are areas where there are probably greater potential savings. Undoubtedly, communities in a region should plan jointly for major hospital expansions and should work out together what expensive but highly specialized equipment (e.g., a cobalt X-ray machine for cancer treatment, or an artificial kidney) should be bought by which hospital in the area.

There is a good deal of such planning going on today, and much more is needed. At its most effective it can save a few pennies of the hospital dollar. Anything much beyond this would again require tremendous social and psychological changes—giving up, for

instance, the autonomy of the community hospital and the pride and interest of the citizens and of the town's physicians in it.

The Wrong Question

A few years ahead, when Medicare and its costs are digested and the health-service employees are brought up to the prevailing income levels, health-care costs should level out. Within a few years, in other words, we will have largely reached the goal of adequate health care for everyone (except the mentally sick) which we have set for ourselves.

But few people will see this.

On the contrary, we will, when the bulk of the job is behind us, engage in a furious debate over health care, what's wrong with it, and who is to blame. It is human nature to look for villains and for a conspiracy when something happens that we did not expect to happen—and it is only now that the American people begin to realize what they committed themselves to when they accepted the goal of full health care for everyone. We shall therefore read attacks on the doctors and the hospitals, on the standards of medical schools and medical practice, and so on. Undoubtedly there is a lot that needs fixing in health care; we have, after all, stitched a multi-billion-dollar system together in a tearing hurry. However, the real question is no longer: How much should health care cost? It is: What should we expect to get for our health-care investment? It is a question of objectives.

When asked what we expect to get, almost everyone says, "That's obvious; we expect to get health." But that is **not** what we are paying for, and it is **not** what we get. We pay for and get treatment of major diseases and prolongation of life—and these are, of course, worthwhile.

But the number of sickness days

among the adult population of working age or among the young has not gone down markedly. It may even be going up. The great bulk of sickness leading to the loss of working days (the only area where we have figures) is caused by discomforts rather than by serious illness, by colds, minor stomach upsets and, among women, by menstrual complaints. If "health" is defined as the capacity to function at a normal level, these minor complaints are major health hazards.

They could probably be reduced with fairly small efforts. There is, for instance, the experience of a leading school of nursing in the Midwest. The student nurses were, of course, young and in robust health and when they fell sick they got the best of medical care. Still, they lost far too many days to sickness. But as soon as they were given a regular monthly health check, lasting only 15 minutes or so per student, the number of days lost to sickness during the school year fell from an average of nine per student nurse to two.

In respect to some of the most serious health hazards, there is also mounting evidence that prevention and early detection could bring drastic improvement. Several major degenerative diseases—circulatory and heart ailments, kidney diseases or emphysema of the lungs, all of which resist therapy—can often be postponed for long years by preventive hygiene. Early detection is clearly the only effective way, so far, to control cancer.

The Health-Giving Art

Yet keeping the healthy healthy is not being paid for by Blue Cross/Blue Shield, private insurance or Medicare. They pay only for repair after the damage has been done. Blue Cross is even reluctant to accept as a legitimate hospital cost the expenses for a

"Health Education Service" such as some big hospitals (e.g., United Hospitals of Newark, New Jersey) are now introducing to help patients stay well after they go home. Indeed, the way our health-care finance is conceived and set up, Blue Cross has a good case; a health education service does not directly contribute to the treatment and cure of the individual Blue Cross subscriber.

Whether we should organize for prevention and early detection, and how we should set up and finance such services, will increasingly be the real health-care question. We have today provided for the financing of the kind of health care that gave medicine its traditional name: "the healing art." But medicine is becoming more and more capable of being also "the health-giving art." And growing numbers of physicians, public-health people and hospital administrators are coming to believe that to confine our health-care finance to paying for repair work is shortsighted, both medically and economically.

A heart murmur does not necessarily mean heart disease. In children, functional or harmless heart murmurs are by far the most common type, according to the North Carolina Heart Association.

. . . When 100 new jobs are created by industrial expansion in a community, 359 more people, 100 more households, 91 additional school age children, 97 motor vehicles, 165 more persons working in trades serving the main industry, \$229,000 in additional bank deposits, and \$710,000 in additional personal incomes are added to the area.

. . . About 40 percent of all radios manufactured in the United States are designed for installation in automobiles.

Miss Audrey Umphlett

Honored by Perquimans

County Friends

Earlier this year the people of Perquimans County were proud to dedicate an issue of the Perquimans Weekly to Miss Audrey Umphlett who has served the county as its chief public health nurse for twenty-three years and had been a public health nurse for 27 years.

Miss Audrey was the nurse hired by Perquimans County Health Department when it was founded twenty-three years ago. During that time she has served the Perquimans County people and except for the physicians is their chief health consultant. She has given thousands of immunizations and referrals.

In the beginning she was the only nurse in the county and the health department was located in rooms above the drug store. In the early fifties it was Miss Umphlett who took the lead in urging the building of the County Health Center located on Charles Street.

Because she has represented health in the schools she is known more by the children than almost anyone in the county. In any tuberculosis cases or those with contagious disease she has offered encouragement for the patient and taught the families how to avoid spreading the disease.

Perquimans is also proud to claim Miss Audrey as one of its natives. She grew up in the Winfall area and was the oldest of nine children of Walter and Minnie Umphlett. There were many setbacks in her educational plans which included two "drop outs" before she obtained her R.N. from Sarah Leigh Memorial Hospital in Norfolk in the thirties. Her picture taken at that time

shows the same smile that has charmed so many youngsters into "not minding her shots". Schoolmates at that time regarded her as unusually kind and remember her partly because she prevented them from adding a strong purgative to the coffee of a dreaded supervisor.

Soon after this time she prepared herself in Public Health Nursing by taking a special course in Public Health from the College of William and Mary in Richmond. At that time it was 1938 and there was no position for a public health nurse in Perquimans County. For five years she worked in Duplin and Northampton counties.

In Northampton her duties were chiefly with the midwives teaching them the practices of cleanliness in delivering the babies. They were all self trained and many of them were using crude methods. For instance cobwebs were used to stop bleeding. Infections resulted and serious consequences fol-



lowed. Her hours at that time were whenever a delivery was in progress and frequently included all night vigils.

Miss Umphlett remembers one night particularly in which she and the midwife had been helping a patient who was in labor. Just at the break of day a rooster which had remained unseen and unheard all night under the bed, rose and gave news it was morning. At the same time a goat stuck his head in the door and bleated a response to the crowing. The baby whose arrival had been imminent, made his appearance in the world at this moment with practically no assistance from the startled helpers.

When the Perquimans County Health Department was established in 1943 Miss Umphlett was the first person hired to work in it. Soon thereafter it became part of the District Health Department. Dr. Dan Hackett was the first health officer. Health facilities such as a laboratory in Elizabeth City was thus made available. Other personnel were added such as secretary and other part time nurses and sanitarians.

Contagious disease investigations and prevention of their spread has always been an important part of her work.

Miss Umphlett recalls the problem of a case of tuberculosis in a worker which was found while he was working with a logging crew. She arranged for him to go to the sanatorium but he hated to go so went back to work. She went into the woods where the lumber was being cut and talked to his boss. He was persuaded to go with her to the bus station. She saw that he bought his ticket and hid behind a crepe myrtle tree to be sure he got on the bus to the sanatorium. Not only was he given an opportunity to get well but many other people were prevented from contact with the disease.

Miss Umphlett is known statewide for

her plan to carry out the law regarding protection of the children with immunizations. In addition she was instrumental in getting the additional requirement in Perquimans County of immunization against typhoid. She also added to the plan to repeat immunizations for smallpox in the seventh and twelfth grades.

Miss Umphlett has never married. In the fifties she took into her home a ten year old niece whose mother died in an accident. This niece is now Mrs. Jil M. White and lives in Hampton, Virginia. Mrs. White's three little girls call Audrey "grandmother" and she is looking forward to spending much time with them and getting to know them better.

The people of the county have all participated in honoring Miss Umphlett for her services. Earlier this year when she was introduced to the high school pupils in connection with a health careers club the youngsters applauded her for several minutes. Many prominent people honored her by attending a reception given for her at the Health Center. The staff gave her a beautiful gift of silver.

At the North Carolina Public Health Association meeting three years ago she was presented with a twenty-five year pin for her service in public health in North Carolina.

The present District Board of Health members from Perquimans, Mr. Vivian Darden, Dr. A. B. Bonner, and Mr. R. L. Spivey joined the Health Director, Dr. Isa Grant, in praising Miss Audrey for her long and successful career in Public Health Nursing. They commended her on the "extras" she had given her job such as her ability to put even the most frightened at ease, her wise counsel in health matters, her professional skills, her personal interest in each individual and in her fine sense of humor.



Graduation for Little Jack and His Friends

Early in June familiar friends of Tar Heel school children, puppets which have promoted better dental health throughout the state, sported their mortar boards in honor of graduation. This year's puppeteers shown conversing with the puppets are Charlotte Dry and Martha Sain. Puppets from the left are Beulah, Judy, Jasper, and Little Jack. These puppets have been telling the story of better dental health to school children for many years, taking about three years to reach every school. Two motion picture films of the puppets' activities have been made, permitting presentation in an additional way besides the current year's live presentation.

Director Named For College Health Association

Lee D. Stauffer was appointed Executive Secretary of the American College Health Association effective July 1, 1966. The appointment of Mr. Stauffer, who has long been active in college health services activities, fills the vacancy created by the death of Dr. Benjamin R. Reiter.

Mr. Stauffer comes to this position from the place as Assistant Professor and Assistant Director, School of Public Health, University of Minnesota, a position he has held since January, 1962.

Born in Wisner, Nebraska, he attended the University of Nebraska, graduating in 1951 with a bachelor of science

degree in English Education. After working one year in his native state, he joined the staff of the University of Minnesota Health Service. While serving in various capacities, he continued his formal education and in 1956 received his M.P.H. degree.

Mr. Stauffer has served as a consultant to the U. S. Public Health Service and to many state and local health agencies. He also has written extensively in his professional field.

He is a Fellow, American Public Health Association and a member of several other professional organizations, including the Minnesota Society of Professional Sanitarians, National Association of Sanitarians, and the Minnesota Public Health Association.

New Leaflet Warns Against Foodborne Illness

Most cases of foodborne illness in the United States are preventable but continue to occur because people preparing and serving food fail to apply known food-protection measures. To warn housewives and restaurant chefs of this danger, a new leaflet, "Hot Tips on Food Protection," has been published by the Public Health Service Division of Environmental Engineering and Food Protection.

Among foodborne illnesses which may result from improper cooking, the leaflet points out, are:

Salmonellosis, a food infection coming from the presence of *Salmonella* organisms which may be found in poultry, eggs, and egg products, even if frozen.

Trichinosis, a foodborne disease transmitted to humans through raw or undercooked pork which may have a parasite, *Trichinella spiralis*, in muscular tissue.

Staphylococcal food poisoning, an illness caused by a toxin made by *staphylococcus* organisms sometimes present in cream-filled pastries and custards.

Botulism, a sometimes fatal disease, caused by *Clostridium botulinum* organisms (commonly present in soil) which, unless destroyed by proper canning techniques, may form a toxin in certain canned foods.

The leaflet explains how proper cooking and handling of foods which have often been incriminated in outbreaks of foodborne illness may help to eliminate these and other kinds of food poisoning.

The new leaflet, PHS Publication 1404, is for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. at 10¢ a copy.

Individual free copies may be obtained from the PHS Public Inquiries Branch, Washington, D. C. 20201, or from Regional Offices of the U. S. Department of Health, Education, and Welfare (Attention: PHS Regional Program Director, DEEFP) in Boston, New York, Charlottesville (Va.), Atlanta, Kansas City (Mo.), Chicago, Dallas, Denver, and San Francisco.

A combination of strenuous exercise and hot, humid weather both add to the work of the heart, the North Carolina Heart Association suggests.

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Medical Self-Help Training Report

January through May 1966

During the first five months of this calendar year, Medical Self-Help Training has been reported from the following 35 counties:

County	No. Reported	County	No. Reported
Brunswick	25	Johnston	876
Buncombe	1,251	Lee	80
Burke	15	Lenoir	122
Cabarrus	37	Mecklenburg	38
Chatham	77	Nash	85
Cleveland	16	Northampton	19
Cumberland	70	Onslow	39
Davidson	16	Orange	80
Davie	164	Person	148
Duplin	393	Pitt	777
Durham	367	Sampson	254
Forsyth	2,706	Vance	755
Franklin	299	Wake	1,031
Granville	503	Warren	373
Greene	346	Wayne	1,737
Guilford	2,087	Wilson	56
Halifax	5		
Harnett	661		
Hoke	23		

Summary of reporting since March 1963:

Time Period	Total Number	Number of Counties Reporting
1963 — March through December	2,011	23
1964	4,666	19
1965	7,006	30
1966 — January through May	15,522	35

North Carolina ranks 25th among the 50 states in the total number of students trained. The state now is 11th in population.

Note: Several counties have sent in statistical information on previously unreported classes which will be included in next month's report when the information can be transcribed to official report forms.

A vacation is a good time to play. The North Carolina Heart Association suggests, however, don't play around with your heart by overdoing. The heart's best prescription is moderation.

* * *

The energy which is provided by the pacemaker to the heart is about one-

thousandths of a volt per heartbeat, says the North Carolina Heart Association.

* * *

No two heart cases are exactly alike and only a doctor can give you specific advice about your child's heart or your own, the North Carolina Heart Association says.

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DATES AND EVENTS

- July 18-24 — International Congress of Occupational Therapists, London
August 3-10 — International Congress on Nutrition, Hamburg
August 29 - Sept. 1 — American Hospital Association, Chicago
Sept. 4-10 — International Conference of Social Welfare, Washington, D. C.
Sept. 5-7 — International Conference on Water Pollution Research, Munich
Sept. 8-10 — N. C. State Employees Convention, Durham
Sept. 15 — N. C. Rural Health Conference, Hotel Sir Walter, Raleigh, N. C.
Sept. 19-24 — International Congress on Occupational Health, Vienna
Sept. 25-29 — Water Pollution Control Federation, Kansas City, Mo.
Sept. 27-28 — American Medical Association — Council on Occupational Health, Portland, Oregon
Sept. 29 - Oct. 2 — American Medical Writer's Association, New York
Oct. 2-5 — National Rehabilitation Association (National Conference) Denver
Oct. 3-7 — International Clean Air Con-

- gress/International Union of Air Pollution Prevention Assn., London
Oct. 5-7 — N. C. Public Health Association, Robert E. Lee Hotel, Winston-Salem
Oct. 10-15 — STATE FAIR WEEK
Oct. 13-16 — American Occupational Therapy Association, Minneapolis
Oct. 16-18 — 19th Annual Conference on Family Life, Battery Park Hotel Asheville

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

July 1966

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Longest Term of Service Recognized

Dr. Jacob Koomen, State Health Director, presented a certificate of appreciation to Mrs. Margaret P. Copeland, Supervisor in the Vital Statistics Section, who retired June 30 after 43 years and 3 months of service with the State Board of Health.

Public Health Physicians Retire

Three public health physicians were in the group of State Board of Health employees who retired June 30. Seen in the picture from the left are William A. Smith, M.D., Chief of the Tuberculosis Section, serving 18 years, 1 month; the late Fred T. Foard, Jr., M.D., Director and Consultant, Epidemiology Division, 13 years, 7 months; and Charles B. Kendall, M.D., Chief, Crippled Children's Section, 13 years.



Manpower for Better Health Services

by
Surgeon General
William H. Stewart

Dr. Stewart, Surgeon General of the Public Health Service, delivered the address on which this paper is based at the Joint Conference on Job Development and Training for Workers in Health Services, sponsored by the U.S. Department of Labor and the U.S. Department of Health, Education, and Welfare, Washington, D. C., February 17, 1966.

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MORE AND MORE, the physician is functioning as a manager — a job for which he is not specifically prepared, either by training or by tradition. Typically, he used to be a soloist. At most he was the director of a small, compact team in which each individual's role was clearly delineated. Today he must direct the efforts and energies of a growing number and variety of health workers.

As the managerial function of the physician increases, so does his dependence upon others. If he is to succeed in the task for which he has spent a quarter of a century in educational preparation, each member of his corps of supporters must perform to specifications. Their skills must interlock in the right way at the right time. And the highest possible wager—human life—is riding on the outcome.

Thus the training of supportive health workers is of much more than academic interest to the physician. He stakes his professional life on their competence every day. As medicine advances in complexity, his dependence cannot possibly diminish; it can only increase.

The magnitude of the training challenge is enormous. Today in medicine, dentistry, nursing, and the other health professions there are perceived needs for over 500,000 additional workers—a number far greater than the national training capacity.

Two things must be done. First, we must augment and make the best possible use of programs and facilities for training professional health workers. Second, we must give greatly increased effort to the analysis of health service functions, to the development of meaningful technician and assistant groups, and to the development and support of training programs which will prepare people to work together much more effectively.

The number of workers in the health

occupations increased at a rate of 3 percent a year between the 1950 and the 1960 census. If this rate continues, the totals will increase from about 2.4 million this year to some 3.3 million 10 years from now.

The health service industry has many workers not in the health occupations. Their number has grown even faster. In the health occupations the annual rate of increase has been 3 percent. The number in the health service industry has been increasing at a rate of about 4 percent. If growth should continue at between 3 and 4 percent, we should add 1.0 to 1.5 million health service workers in the next 10 years.

Training Health Workers

There is also a qualitative component to training. We cannot neglect quality of preparation to meet the overwhelming challenge of numbers. The cost of carelessness or error is too great. The price of ineptitude is not only the loss of somebody's job but perhaps the loss of somebody else's life. We must do more than turn out a million health workers in 10 years. We must turn out a million good ones.

Moreover, these people cannot be successfully trained in isolation from the health complex of which they will become a part. Teamwork in medicine is not an assembly line in which each man tightens his particular bolt, more or less irrespective of what happens before and after. Skills don't just touch each other; they are interwoven. A good nurse's aide is constantly growing in her understanding of the nurse's job. A good nurse develops many of the capabilities of the physician.

Many of the barriers that now exist are arbitrary. They were placed by the traditions of another era and are maintained by thinking more appropriate to a guild of the Middle Ages than to a modern profession. There is

a need for career ladders in the health professions. I think this need extends through the subprofessional levels as well, crossing the no man's land where the prefix "sub" is tacked onto the word "professional."

I might add parenthetically that we ought to find a better word than that patronizing term "subprofessional" — a word that is used only by professionals.

Our aim is not just to recruit and retain bodies. At every entrance level, we want to challenge the people with promise. For many bright young men and women who might join the health enterprise after leaving high school, the road to a medical degree would seem impossibly long. But there is no reason for us to train them in such a way that we put a heavy lid on their

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Vol. 81 July, 1966 No. 7

aspirations.

Today, in order to advance upward in the health disciplines, it is generally necessary to go back to the beginning and start over. Academic credits acquired in pursuit of one occupational goal rarely count toward a higher goal, and work experience is generally undervalued. This is extremely discouraging to the individual. It is also extremely wasteful of talent that will always be in short supply. The guild system is a luxury we cannot afford.

Channeling Manpower

Obviously there is no single answer to the problem of providing health manpower to meet the demand of the future. Many courses of action are already underway, under many sponsorships, and designed to meet many separate needs. This is a healthy condition. It would become unhealthy only if each separate course of action should become, in turn, a self-contained compartment to be buttressed and defended, building a new set of rigidities into a system that is desperately in need of the fluid and flexible.

This will not happen if the schools and institutions carrying out the training, and the agencies to which they turn for support, keep their eyes firmly fixed on the purpose of the whole endeavor

—the provision of better health services for more people. All these separate channels must converge upon health care. By the same token, someone must keep track of the changing and growing manpower resource. Someone needs to be able to say, authoritatively, which channels are overflowing and what new courses must be developed.

The primary burden rests squarely upon the health professions themselves. We must furnish the answers to the basic questions: What kinds of training? For how many? And finally, after training, what? How shall we make use of the outpouring of human talent and energy that these training programs will generate? How can we best mobilize this growing resource and direct it toward the health needs of the people we serve?

At the outset, we have to admit that we have not been overwhelmingly successful in using the talent we already have. Medical research has been quick to catch the accelerating tempo of our times. By comparison, medical practice has been slow. We are barely beginning to exploit the potential of automation. The organizational patterns of health service are not yet generally adapted to the widespread delivery

(Continued on Page 10)

At a reception honoring retirees from the Division of Epidemiology, Dr. Martin P. Hines, Division Director, is seen in one of the lighter moments, presenting a miniature rocking chair to Miss Mallie M. Evans who retired June 30 from that division after 34 years, 9 months' service with the State Board of Health.





"THE LOST COLONY" IS CHANGING THE SHAPE OF THE LANDSCAPE

In a number of ways, Roanoke Island is reflecting Paul Green's exciting drama, "The Lost Colony". Amidst the natural wonders of sand, sea and shell, of wildflowers and wildfowl, of fishing sounds and dogwood trails, are many pleasant places to stay overnight. Burwell and Ina Evans, Innkeepers in Manteo, have built "quarters fit for Queen Elizabeth" in their Elizabethan Manor, an authentic Elizabethan architectural design in the historic setting of the first English Colony in America. These choice accommodations and the motel and restaurant adjoining add to the other motels, hotels and recreational resources of this area and to the comfort, convenience and pleasure of the thousands of visitors to our Eastern Coast, during the summer particularly, and even throughout the whole year.





HUMAN TOTEM POLE — One of the spectacular scenes in "The Lost Colony" outdoor symphonic drama is a human totem pole of harvest-celebrating Indians. "The Lost Colony" is in its 26th production season through August 28, 1966 in the Waterside Theater, Fort Raleigh National Historic Site, Roanoke Island, Manteo, North Carolina.

Retiring Employees

Honored in Special Ceremony

Fourteen Staff Members Retire

Shown here are ten of the 14 staff members of the State Board of Health who retired June 30, 1966, and were honored in a special ceremony of appreciation in the John Homer Hamilton Auditorium. These represent a total of 290 years of service. From the left, those in the picture, with their division and length of service, are: (standing) Fred R. Blackley, Dental Health, 10 years, 6 months; Dr. Hubert B. Sapp, Dental Health, 3 years, 8 months; Mr. A. R. Reep, Local Health, 22 years, 6 months; Dr. Charles B. Kendall, Personal Health, 13 years; Dr. Fred T. Foard, Epidemiology, 13 years, 7 months; and Dr. William A. Smith, Epidemiology, 18 years, 1 month. Seated, are Mrs. Virginia J. Perry, Epidemiology, 23 years, 3 months; Mrs. Margaret P. Copeland, Vital Statistics, 43 years, 3 months; Mrs. Clela B. White, Epidemiology, 20 years; and Miss Mallie M. Evans, Epidemiology, 34 years, 9 months. Other retirees not present for the picture were Mrs. Clara Hart, Laboratory, 7 years; Mrs. Ruth R. Mebane, Epidemiology, 36 years, 11 months; Mrs. Myra B. Murchison, Epidemiology, 21 years, 3 months; and Miss Cora E. Wyatt, Laboratory, 22 years, 3 months.





Manpower

(Continued from Page 5)

of the right care to the right patient at the right time. We have not yet mastered the effective employment of specialization. We are just starting to pass through the managerial revolution that has reshaped industry and science.

There are, however, many hopeful signs. Routine chores are increasingly delegated to assistants. Computers are being allowed to do the things they can do faster and better than people. I believe the day is rapidly approaching when health professionals and their associates will be using their highest skills far more efficiently in behalf of their patients.

Even when that day arrives, some questions will remain to be answered. The abstract problem of applying health manpower to health need is at root a human problem and must be considered in human terms. I should like to conclude by posing a couple of these human problems for which I have no handy solution. The problems are cast in terms of health professionals, nurses and physicians, but they are similarly applicable to other health disciplines.

Human Problems

Consider, first, the classic dilemma of the nursing profession. It is axiomatic that for every practicing professional nurse several have fallen by the wayside. Either they do not finish school or they enter the profession and subsequently leave it for marriage and a family. The mystery is not why the nurses leave, but why the profession has not accommodated itself to the natural and inevitable. It seems to me that there must be ways whereby a nurse can be married and raise a family without being irrevocably lost to her profession.

I have the impression, for example,

that maternity leave provisions in most health enterprises are far less liberal than those in industry and government. I am not aware of any systematic provision of refresher courses for nurses who would like to return to the profession after a few years' absence. I don't know of many institutions in which a nurse can practice a few hours a day, or a couple of days a week, to contribute her much needed skills at times which do not conflict with her family responsibilities.

I have heard one serious proposal to build, next to a hospital, a large and attractive apartment house specifically designed for nurses and their families. Day nursery services for young children and other features would help overcome the many minor hardships that now discourage the married woman from practicing her profession. Whether or not this becomes a reality, it represents creative thinking in the right direction. We need more of it.

The second problem concerns a young physician who, after about 25 years of education, is ready to finish the last year of his internal medicine residency and set up practice. What are the chances that he will locate where his skills are needed most, and how can those chances be influenced in favor of applying talent to need?

We talk glibly about equal access to health services as a major goal for the future. But health professionals are human beings. They want to locate where the money is—or where they think it is. They want to locate where they can continue the stimulating professional associations to which they have become accustomed and want their children to go to the best schools. The deck is heavily stacked **against** equal access to their services for rural Americans, for slum-dwelling Americans, for small-town Americans.

Again I have no all-inclusive answers

to propose. The idea of locating physicians by fiat would be totally unacceptable in our society. Certain strictly economic incentives, such as forgiveness features in loan programs, have been tried with inconclusive results. We know that physicians who choose to practice in small towns and rural areas are usually those with rural or smalltown origins; but we know also that a very small proportion of medical students come from such areas, and that many of them are won over by the advantages of the metropolitan environment.

Somehow, the conditions of practice in areas of special need must be made attractive and challenging. In terms of one important factor, the stimulating professional association, I believe we are making a significant start in the regional medical programs for heart disease, cancer, and stroke. Under this concept, the health services of an entire region will be linked to a central focal point of medical excellence, with built-in provisions for continuing professional education, interchange of personnel, and systematic consultation and referral on individual cases.

But we still have a long way to go to counteract the unfortunate tendency for the rich to get richer and the poor to get poorer in terms of available health services. As with our other problems, we shall need all the creative thinking we can find in the days ahead.

The necessity for thinking in large numbers — hundreds of occupations and millions of workers—carries with it an implicit danger. We are dealing with health care. Health care is perhaps the most compellingly human of all occupations.

In mobilizing our army of health workers, let us remember that it is not an army. We have no battalions and regiments to be pressed into service and ordered wherever the need is

greatest.

Rather, we are dealing with individual human beings who, we hope, will choose to enlist in the health enterprise and serve it to the height of their capacity. Their free choice can be our greatest asset. If we perform our training functions well, and if we design our health resources so as to encourage full individual development, we will achieve the kind of competence and dedication we need to advance the health of our people.

Chapel Hill Professor Succumbs

Dr. Robert Ervin Coker, Jr., 55, chairman of the University of North Carolina Department of Public Health Administration, died of a heart attack Sunday afternoon, July 31, at North Carolina Memorial Hospital.

Dr. Coker had been a member of the UNC faculty since 1956.

Dr. Coker graduated from the University of North Carolina in 1932 and received his M.D. degree from Johns Hopkins University in 1940, and a master of public health degree in 1947.

He served as a medical officer in World War II, in the U. S. Navy and was director of the Alamance County Health Department in 1950-51. He was associate director for the Local Health Division of the North Carolina State Board of Health in 1952-53.

Dr. Coker wrote extensively on public health subjects, particularly about public health careers and was chairman of the Health Officers Section of the American Public Health Association.

Dr. Coker is survived by his wife, the former Mary Martin of Weyburn, Saskatchewan, Canada, and two children, Robert Martin and Mary Elizabeth; his mother and father, Dr. and Mrs. R. E. Coker, of Chapel Hill.

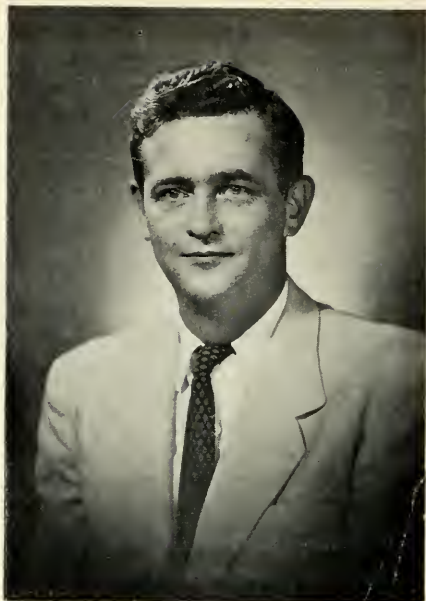
**IN MEMORIAM
DR. JOHN E. ZELIFF
1921-1966**

We were all saddened by the sudden death of Dr. John E. Zeliff, Pediatric Consultant of the Maternal and Child Health Section, on Tuesday, June 28.

Dr. Zeliff was born in Warren, Pennsylvania, November, 1921. He received his medical degree from the Duke University School of Medicine. Before joining the State Board of Health, he practiced medicine in Greenville, S. C.

He was a member of the American Medical Association, South Carolina Medical Association, North Carolina Pediatrics Society, South Carolina Pediatrics Society, American Board of Pediatrics and the Academy of Pediatrics.

His jovial manner and his kindness toward his fellowman will be greatly missed at the State Board of Health.



John E. Zeliff

**IN MEMORIAM
JOHN MENDALHALL GIBSON
1899 - 1966**

We were all saddened by the sudden death of Mr. John M. Gibson on July 16th. He had served as Research Librarian with the North Carolina State Board of Health since June 1, 1954.

A native of Gibson, he graduated from Columbia University in 1921, and was the former associate editor of the "Daily Berlin American" which at that time was the only daily newspaper in Europe published in English. He was the author of four books, "Physician to the World," "Those 163 Days," "Soldier in White" and "Soldiers of the Word."

His love of history was well known and he delighted in sharing his knowledge with all who knew him. He will be missed by his many friends at the State Board of Health.



John M. Gibson

**IN MEMORIAM
DR. JAMES F. DONNELLY
1914 - 1966**

The death of Dr. James F. Donnelly on June 24, ended a career in public health which covered many years.

Dr. Donnelly had been with the State Board of Health for twelve years. As Director of the Personal Health Division, he was also responsible for administering the State's responsibilities under the Federal Medicare Program. Dr. Donnelly was also a member of the faculty at the University of North Carolina's Schools of Medicine and Public Health at Chapel Hill.

A native of Pennsylvania, he had lived in North Carolina for about 25 years. He received his medical degree from the University of Chicago. Before he joined the State Board of Health he was a professor of obstetrics at the Bowman Gray Medical School in Winston-Salem.

He was author of a score of articles in medical journals over the years. He was affiliated with various medical and public health organizations.

Dr. Donnelly will be greatly missed as a friend, professional colleague and contributor to good health.



James F. Donnelly



Gifts for Long Terms of Service

Mrs. Margaret P. Copeland (left) with over 43 years of service at the State Board of Health, and Mrs. Virginia J. Perry, with over 23 years, are presented gifts by fellow employees at a special ceremony as they and twelve others retired in June.

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TABLE 2—CHANCES IN 100 THAT
A WOMAN WILL SURVIVE FOR
SPECIFIED NUMBER OF YEARS
United States, 1964

Present Age	Years of Survival				
	5	10	15	20	25
35.....	99	98	96	93	89
40.....	99	97	94	89	83
45.....	98	95	91	84	75
50.....	97	93	86	77	65
55.....	96	89	80	67	50
60.....	93	83	70	53	32
65.....	89	75	57	35	14*

*Estimated.

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MORTALITY FROM MOTOR VEHICLE ACCIDENTS
Selected Countries, 1959-1964

Country Ranked According to Motor Vehicles per 100 Population	Death Rate per 100,000 Population*						Death Rate per 100,000 Registered Motor Vehicles	Percent Pedestrian Deaths of Total	Motor Vehicles per 100 Population
	1959	1960	1961	1962	1963	1964	1963	1960-62†	1963
United States	21.5	21.3	20.8	22.0	23.1	24.5	52.6	17	43
Canada	21.1	20.7	21.3	23.3	23.6	25.3	74.6	29	33
Australia	24.0	25.6	24.7	24.6	24.5	26.6	78.7	30	32
New Zealand	15.5	15.0	16.7	16.9	16.5	16.5	53.8	24	31
Sweden	13.9	14.6	15.2	15.7	16.7	17.5	76.1	30	22
England and Wales	13.3	14.5	14.4	13.5	13.5	15.3	76.3	40	18
Scotland	11.7	13.0	13.8	13.0	14.1	—			
France	18.3	18.2	19.6	20.9	20.8	22.9	112.9	24	18
Denmark	17.7	16.9	18.8	17.9	17.9	—	101.8	28	18
Northern Ireland ..	11.9	12.5	13.2	10.5	12.4	—	83.1	39	15
Switzerland	20.2	22.9	23.4	23.7	22.3	—	153.0	31	15
Germany, Federal Republic ..	24.8	25.6	25.6	25.4	25.0	—	159.8	—	15
Norway	8.6	8.4	10.4	9.5	11.0	—	82.3	38	14
Belgium	16.2	19.1	18.4	17.8	18.5	—	133.9	14	14
Ireland	8.6	8.9	10.1	9.7	10.1	—	104.0	42	10
Austria	29.0	27.6	22.2	20.9	24.4	27.3	242.9	—	10
Italy	15.9	17.2	19.2	21.1	22.2	—	257.0	56	9
Netherlands	14.9	16.6	16.5	17.6	16.7	—	186.7	18	9
Finland	14.1	17.1	17.7	18.2	20.5	—	261.2	36	8
Japan	11.9	14.4	15.7	14.5	15.7	—	402.2	41	4

*Not adjusted for differences in age distribution among the various countries.

†Italy, Japan and Switzerland data are for 1959-61.

Source: Mortality—mainly World Health Organization, *Monthly Epidemiological and Vital Statistics Reports*; reports of various countries. Motor vehicle registration—from *Automobile Facts and Figures*, Automobile Manufacturers Association.

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DATES AND EVENTS

- Sept. 4-10—International Conference of Social Welfare, Washington, D. C.
Sept. 5-7 — International Conference on Water Pollution Research, Munich.
Sept. 7-9 — Conference on Service and Training—Home Health Service, Winston-Salem.
Sept. 8-10 — N. C. State Employees Convention, Jack Tar Hotel, Durham.
Sept. 15 — N. C. Rural Health Conference, Hotel Sir Walter, Raleigh.
Sept. 19-24—International Congress on Occupational Health, Vienna.
Sept. 25-29 — Water Pollution Control Federation, Kansas City, Mo.
Sept. 27-28 — American Medical Association — Council on Occupational Health, Portland, Ore.
Sept. 29 - Oct. 2 — American Medical Writer's Association, New York.
Oct. 3-5 — National Rehabilitation Association—National Conference, Denver, Colo.
Oct. 3-7 — International Clean Air Congress/International Union of Air Pollution Prevention Association, London.
Oct. 5-7 — N. C. Public Health Association, Robert E. Lee Hotel, Winston-

Salem.

- Oct. 6-7 — Invitational Conference by National Cancer Foundation on "Catastrophic Illness; Impact on Families," Biltmore Hotel, New York.
Oct. 10-15 — STATE FAIR WEEK
Oct. 13-16 — American Occupational Therapy Association, Minneapolis.
Oct. 16-18 — 19th Annual Conference on Family Life, Battery Park Hotel, Asheville.
Oct. 16-20 — American Association of Medical Record Librarians, Milwaukee.

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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Fred T. Foard, M.D.
1889 - 1966

IN MEMORIAM
DR. FRED T. FOARD
1889 - 1966

Dr. Fred T. Foard, a 47-year veteran of public health work and former director of the Epidemiology Division of the State Board of Health, died Sunday, August 7th. He was 77.

Dr. Foard died at Baptist Hospital in Winston-Salem after he was injured the day before in a two car accident near Newton.

Dr. Fred T. Foard was born March 30, 1889. He was the son of the late Dr. Fred T. Foard and the late Mrs. Frances H. Foard of Catawba County, North Carolina.

After graduating in medicine at the University of Maryland, Baltimore, in 1916 he served his medical internship at the U. S. Marine Hospital, Boston, Mass. and was employed for field duty in U. S. Army Cantonment Zones by the U. S. Public Health Service for the duration of World War I. He remained as a commissioned officer of the U. S. Public Health Service for 35 years, until he retired from the Public Health Service as Medical Director in October 1952.

Upon his retirement from the Public Health Service, Dr. Foard was immediately employed as Director of the Division of Epidemiology for the North Carolina State Board of Health, where he continued until his retirement late in 1964.

Following the close of World War I in 1919, Dr. Foard was sent to Montana to be engaged in the beginning development of full-time health services in counties of that state and other states of the Rocky Mountain and Pacific Coast area, Hawaii and Alaska. A major portion of this 35 years with the Public Health

Service was spent in the western part of the United States, with his headquarters in California where he continued the development and improvement of state and local health services of the Far West. Following the close of World War II, Dr. Foard was assigned as Medical Director of the activities of the U. S. Public Health Service in Puerto Rico and the Virgin Islands with his headquarters in San Juan, P. R. In 1947 he was returned to Washington, D. C., to be placed in charge of all health and hospital services of the Indians of America and the natives of Alaska, then a responsibility of the U. S. Department of the Interior. During the following four years, he was responsible for bringing about major improvement in health services provided for the Indians and for the transfer of the entire Indian Health Program from the Department of the Interior to the U. S. Public Health Service where Indian health and hospital programs have been greatly improved and expanded under the U. S. Public Health Service of the Department of Health, Education and Welfare.

Dr. Foard Received Many Honors

For his pioneer work in the development of local health services and the improvement of state health services in the Far West, also for his having later brought about great improvement in preventive health work and hospital services for the Indians of America and the Indians and natives of Alaska, Dr. Foard was awarded the American Public Health Association's Sedgwick Medal in 1960. The citation in connection with this award, given to only one individual each year, was for Distinguished Service in the Field of Public Health throughout his career. In 1959 Dr. Foard was given the Reynolds Award by the North Carolina Public Health Association for Distinguished Contributions to Public Health in North Carolina. In 1960 he was given an honorary degree of Doctor of Laws by the University of North Carolina where he received his premedical training in 1910 and 1911.

On the completion of his assignment as Medical Director of Indian Health Services in October 1952, the Distinguished Service Medal and Citation of the Department of the Interior was awarded Dr. Foard by the Secretary of the Interior.

In October 1949 he received certification in Preventive Medicine and was granted a lifetime certificate in that field by the American Board of Preventive Medicine and Public Health.

Dr. Foard was a Fellow of the American Public Health Association, of which he had been a member since 1919. He was a Fellow of the American College of Preventive Medicine, a member of the American Association of Public Health Physicians, a member of the North Carolina Public Health Association, an Honorary Life Member of the Northern California and Idaho Public Health Associations, a member of the American Medical Association and a member of the North Carolina State Medical Society. He was a Mason and a Shriner.

After 47 years of active service in the field of Public Health and Preventive Medicine before his retirement as Director of the Division of Epidemiology late in 1964, Dr. Foard completed a long, interesting and effective career in his chosen field. He continued as a consultant to the State Board until his retirement on June 30th of this year.

North Carolina Man Receives Honors From Medical Technologists

A North Carolina man received national honors during the American Medical Technologists 28th Annual Convention, July 12-16, at the Fontainebleau Motor Hotel, New Orleans, Louisiana.

The Technologist of the Year Award went to Marvin H. Palmer who resides at 22 Pinehurst Court, Asheville. The award is given for outstanding work in promoting the high ideals encompassed in medical technology.

Of the more than 10,000 technologists registered with the national registry of American Medical Technologists, only one member is selected to receive this award each year. Presentation was made at the Awards Banquet on Saturday, a social highlight of the four-day educational seminar, whose theme this year was "Unity of Purpose—Excellence in Medical Technology".

Since joining the American Medical Technologists in 1952, Mr. Palmer has held several responsible laboratory positions. He is presently employed as Laboratory Director of the Buncombe County Health Department in Asheville.

Mr. Palmer is a member of several health organizations, including the American Public Health Association and the North Carolina Public Health Association.

Mr. Palmer is also active in the North Carolina State Society of American Medical Technologists, and has served two terms as State President.

WORLD HEALTH GROUP CHANGES NAME

The Board of Directors of the National Citizens Committee for World Health Organizations has unanimously voted to change the name of the group to AMERICAN ASSOCIATION FOR WORLD HEALTH, according to an announcement May 16th made by Basil O'Connor, President.

Mr. O'Connor's announcement said that the name change reflects the Committee's growth into an Association of many organizations and individuals with a broad interest in encouraging international health work.

The recovery of a patient depends as much on nursing imagination and invention as it does on the medical skills of a doctor.

—Albert Schweitzer

The Health Bulletin

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Vol. 81 August, 1966 No. 8



NATIVE TAR HEEL BECOMES ASSISTANT DEAN AT UNC SCHOOL OF PUBLIC HEALTH

Charles L. Harper, a native North Carolinian, has joined the University of North Carolina School of Public Health here as assistant dean for finance and administration.

For the past two years he has been associate director of the Department of Public Health in Washington, D. C.

He was director of administrative services for the N. C. State Board of Health in Raleigh from 1960 to 1964. His associates in the State Board rejoice in his return to the state.

Harper received a master of science degree in public health at UNC here in 1950 and immediately joined the Richmond (Va.) Department of Public Health, leaving there six years later as chief of the Medical Care Bureau.

From 1956 to 1960, he was an administrative methods consultant with the U. S. Children's Bureau.

Harper is a 39-year-old native of Lenoir County. His parents, Mr. and Mrs. Stanley Gillispie, live at 2309 Pineway Dr. in Orlando, Fla.

He is married to the former Katherine Hatcher, daughter of Mr. and Mrs. Fred Hatcher of Lilesville.

The Harpers have four children, Charles Jr., 13, Terry, 12, Mark, 6, and Kathy Page, 4.

ADULTS WEIGHED IN THE BALANCES

Adults in the United States weigh more on the average than their Canadian and British counterparts in the 1953 and 1943 studies in those countries and than the insured Americans in the 1959 study of the Society of Actuaries. Among men 18-64 years of age, Canadians were found to average 5 pounds lighter, British 19 pounds less, and insured Americans 6 to 7 pounds less than American men. For women of this age Canadians were 5 to 6 pounds less, British 14 to 15 pounds lighter, and insured Americans 10 to 11 pounds less than American women.

**From: Weight by Height and Age of
Adults—United States—1960—
1962 U. S. Department of
Health, Education and Wel-
fare Public Health Service**

DR. SCURLETIS NAMED ACTING DIRECTOR . . .

Dr. Koomen has asked Dr. Theodore Scurletis, Chief, Maternal and Child Health Section, and one who is thoroughly familiar with the Division's responsibilities, to serve as Acting Director of the Personal Health Division.

Preliminary

PROGRAM

55th Annual Meeting — 1966
NORTH CAROLINA PUBLIC HEALTH ASSOCIATION

October 5-7, 1966
Hotel Robert E. Lee — Winston-Salem

Program Theme
"REGIONAL ORGANIZATION FOR HEALTH SERVICES"



1966 N.C.P.H.A. OFFICERS: From left to right are, R. W. Brown of Asheville, President; Mrs. Corrina Sutton of Raleigh, President-Elect; Mrs. Mildred Kerbaugh of Raleigh, Treasurer; Miss Jane Wentworth of Asheville, Secretary; and Dr. George Dudney of Raleigh, Vice-President.

Officers of the North Carolina Public Health Association

In the picture, from the left, R. W. Brown of Asheville, President; Mrs. Corrina Sutton of Raleigh, President-Elect and Program Chairman; Mrs. Mildred Kerbaugh of Raleigh, Treasurer; Miss Jane Wentworth of Asheville, Secretary; and Dr. George Dudney of Raleigh, Vice-President.

Program Detail

WEDNESDAY, OCTOBER 5

- 10:00 a.m. - 8:00 p.m.** Registration
N.C.P.H.A. members and guests
Lobby
- 12:00 noon** Luncheon followed by business meeting
N.C.P.H.A. Governing Council
Meeting Room 102
- 5:30 p.m.** Social Hour
N.C.P.H.A. Governing Council
President's Suite
-

NORTH CAROLINA ACADEMY OF PREVENTIVE MEDICINE AND PUBLIC HEALTH

OFFICERS — 1965-1966

President _____ Dr. Elizabeth C. Corkey, Charlotte
Vice-President _____ Dr. M. B. Bethel, Raleigh
Secretary-Treasurer _____ Dr. John T. Gentry, Chapel Hill

- 3:00 p.m.** Business Session
Dr. Elizabeth C. Corkey, Presiding
Salem Room
Academy Members
- 3:30 p.m.** First Scientific Session
Dr. M. B. Bethel, Presiding
Salem Room
All Public Health Physicians and Dentists invited
"Grants and Grantsmanship"—Dr. W. Fred Mayes, Dean
School of Public Health, University of North Carolina,
Chapel Hill, North Carolina
- 5:30 p.m.** Social Hour followed by dinner
State Room
Academy Members and Guests
- 8:00 p.m.** Second Scientific Session
Dr. Elizabeth C. Corkey, Presiding
Ballroom

Open meeting—all public health workers invited

"Environmental—Communicable Disease Project in Gaston County"
Moderator: Dr. Ben Drake
Panel: James Jekel, M.D., U.S.P.H.S.; Fred Donaldson, U.S.P.H.S.;
and Boyce Hunt, Gaston County Health Department

General Sessions

FIRST GENERAL SESSION

Open to Public

CAROLINA THEATRE

Thursday, October 6

8:45 a.m. - 12:00 noon

Presiding ----- Robert W. Brown, President
Invocation
Dedication of Program ----- Dr. Jacob Koomen
Introductions ----- Dr. James A. Finger
Greetings ----- Fred Hauser, Chairman
Forsyth County Board of Commissioners
Welcome ----- M. C. Benton, Mayor
Town of Winston-Salem
Response ----- Dr. George G. Dudney, Vice-President
Introduction of Keynote Speaker ----- Dr. W. Fred Mayes, Dean
U.N.C. School of Public Health

KEYNOTE ADDRESS

"Regional Organization For Health Services"

Dr. William H. Stewart, Surgeon General
Public Health Service
Department of Health, Education and Welfare
Washington, D. C.

Break (15 minutes) ----- Theatre Lobby
Message ----- Dr. Jacob Koomen, State Health Director
North Carolina State Board of Health
Message ----- Dr. W. Frank Jones, President
Medical Society of the State of North Carolina
ANNUAL BUSINESS MEETING ----- Business
Reports
Revision of Constitution and By-Laws
Election of Officers
6:00-7:00 p.m. ----- Social Hour
Balinese Roof, Hotel Robert E. Lee
All N.C.P.H.A. Members and Guests

SECOND GENERAL SESSION

Ballroom, Hotel Robert E. Lee

Thursday, October 6

7:00 p.m.

Honors and Awards Banquet

Presiding ----- Robert W. Brown, President

Invocation

Introductions ----- Dr. James A. Finger

PROGRAM HONORING DR. J. W. ROY NORTON

Music ----- Arvids K. Snornieks, Bass-Baritone
Nara Z. Snornieks, Pianist

Special Honors ----- Dr. Jacob Koomen, In-Charge

PRESENTATION OF AWARDS ----- Dr. W. Fred Mayes

Courtesies ----- Mrs. Corrina S. Sutton

9:30 p.m. - 1:30 a.m. ----- DANCE

"The Townsman" Combo
Balinese Roof, Hotel Robert E. Lee
N.C.P.H.A. Members and Guests

THIRD GENERAL SESSION

Ballroom, Hotel Robert E. Lee

Friday, October 7

8:45 a.m. - 12:30 p.m.

Presiding ----- Mrs. Corrina S. Sutton, President-Elect

"National Trends in the Field of Planning for Health Services,
Facilities, and Activities" ----- Dr. Charles M. Cameron

The North Carolina Fund ----- Dick First

Presidential Address ----- Robert W. Brown

Break (15 minutes) ----- Mezzanine

SYMPOSIUM ----- Dr. Isa C. Grant, Moderator

"The Changing Philosophy of Manpower Preparation
For Comprehensive Health Services"

Local Health Department ----- Dr. Grant

State Government ----- Claude Caldwell

Voluntary Health Agencies ----- Miss Ruby Isom

Colleges and Universities ----- Charles Harper

SIGNIFICANT DEVELOPMENTS IN HEALTH*

Russell E. Teague, M.D., M.P.H.
Commissioner of Health,
Commonwealth of Kentucky

This past year has produced more significant new developments in the field of health than have appeared in any similar period of our history of organized health programs.

New ideas, new approaches, new leadership, new methodology, new planning, new thinking, new definitions, new approaches to research, reorganization of old programs and institutions, and a raft of new legislation are appearing from all points of the compass.

It is especially appropriate that as our organization meets here in Texas, the home of the President of the United States, who more than anyone else has prompted these changes, we take full cognizance of them and find our proper place in the scheme of things to come.

The natural tendency to resist change and new ideas can be overcome by an intelligent use of the learning process.

This meeting will give us an opportunity to dig into the meat of these new proposals and have first hand from our learned colleagues some of the changes that we will be participating in in the future.

The States of the South Branch have a proud heritage in the public health movement, and our programs have been outstandingly successful in most areas. While in the past we have dealt with many different health problems, mostly involving procedures of primary prevention, it is now apparent that our next great advance will be in pro-

grams dealing with the delivering of personal health care.

Public health personnel must learn all they can about the new developing programs, stand up and be counted, and jump on the band wagon. The final decisions we make will be determined by our enlightened view of the total problem from a new vantage point.

I recently heard a story of a state senator from Oklahoma who was having trouble in making up his mind. It seems that the State of Oklahoma was voting on the repeal of prohibition, and the senator was called upon to make a speech on the subject—his speech follows:

"I had not intended to discuss this subject at this particular time. However, I want you to know that I do not shun a controversy. On the contrary, I'll take a stand on any issue at any time regardless of how fraught with risk it may be.

"You have asked me how I feel about whiskey. Well, brother, here's how I stand on the question. If, when you say whiskey, you mean the Devil's Brew, the Poison Scourge, the Bloody Monster which defiles innocence, de-thrones reason, creates misery and poverty, yea, literally takes the bread out of the mouths of babes; if you mean the evil drink that topples the Christian man and woman from the pinnacles of righteous, gracious living into the bottomless pit of despair and degradation, shame, helplessness and hopelessness, then certainly I am against it with all my power.

"But, if when you say whiskey, you mean the oil of conversation, the philosophic wine and ale that is consumed when good fellows get together, that puts a song in their hearts and laughter on their lips and the warm glow of contentment in their eyes; if you mean Christmas cheer; if you mean

*Keynote address delivered at the annual meeting of the Southern Branch, American Public Health Association, in Houston, Texas, in May.

that stimulating drink that puts the spring in an old man's step on a frosty morning; if you mean the drink that enables man to magnify his joy and happiness and to forget, if only for a moment, life's great tragedies, heart breaks and sorrows; if you mean that drink, the sale of which pours into our treasury untold millions of dollars which are used to provide tender care for our little crippled children, our blind, our deaf, our dumb and our pitifully aged and infirm, and to build highways, hospitals and schools, then Brother, I'm for it."

Then, having been completely unequivocal, depending on your viewpoint, he added the capstone, "That is my stand. I will not retreat. I will not compromise."

While the new developments in health services have unquestionably brought about many questions and frustrations for us, there has probably never been a more challenging, a more dynamic field in which to be employed. Federal legislation, state legislation, medical research, radical changes in the environment, and significant national studies involving the analysis of the nation's community health services and problems are actually offering more opportunities than we can quickly comprehend. The height of public concern for health is represented in the President's messages to Congress, in which he has constantly urged that new efforts be initiated to meet the nation's health problems and outlined the nation's health goals as follows:

- to bring every child the care he needs to develop his capacity to the fullest;
- to reduce infant mortality, concentrating particularly on those minority groups whose death rate is highest;
- to eradicate major communicable diseases as a threat to life and

health in the United States;

- to reduce the burden of mental illness, and mental retardation;
- to cut the toll of the three great killers—heart disease, cancer, and stroke.

President Johnson further indicated in his most recent message that continuous progress would depend upon improving the administration of federal health activities; developing comprehensive health planning and services on the state and community levels; strengthening our system of health care, training needed health workers; increasing research efforts; and taking necessary steps to meet special health problems. He proposed a budget for the fiscal year 1967 of \$4.67 billion—an increase of almost \$1 billion over 1966. In addition, he pointed out in his message that more than \$3 billion in social security trust funds will be spent under Medicare for older citizens; funds for health manpower, facilities, and services would be increased by \$707 million; environmental activities and consumer protection by \$158 million; for health services activities an increase of \$78 million. The budget of the Public Health Service for research, training, and services has grown almost ten-fold in the last twelve years—from \$250 million to \$2.4 billion. It is reported that the President has already sent to Congress a proposed reorganization of health functions of the Department of Health, Education, and Welfare which will be designed to promote career development, encourage flexibility in the use of health workers, provide them with broader opportunities and stimulate higher standards of performance. This matter will be discussed in more detail later at this meeting.

DEVELOPING COMPREHENSIVE HEALTH PLANNING AND SERVICES ON STATE AND COMMUNITY LEVELS.

The President has also taken action

to establish three new and important programs:

First, if the related legislation (Senate Bill 3008) is enacted by Congress, grants will be made available to states and communities to plan greater use of manpower, facilities, and financial resources for planning health services. Mr. Johnson noted in this regard that this effort will require the cooperation of many agencies, institutions, and experts—of state and local governments, of doctors, of nurses and paramedical personnel. Much has been written about the need to pull these "front line fighters" into their closer alignment with where the battle against disease, disability, and death needs to be fought. With the tremendous limitation of manpower, coordination of all resources must be established.

Second, new state formula grants for comprehensive public health services would begin in fiscal year 1968. At present, the Federal Government offers states formula grants for categorical programs dealing with specific diseases. This will be terminated since it leads to an unnecessarily rigid and compartmentalized approach to health problems. However, it will still be possible to obtain funds to support these programs under the total grant of comprehensive planning for the entire health spectrum.

A third new program will make available grants to states, communities, medical schools and hospitals to meet special health problems, beginning the fiscal year 1968. Certain diseases have been discovered to be concentrated just in metropolitan areas, such as tuberculosis and venereal disease. Others, such as rabies and parasitic diseases, are prevalent in other geographical areas. Resources to serve health needs are not strategically distributed throughout the nation; consequently, we need greater flexibility to meet these needs,

utilizing the special grant mechanism.

REGIONAL PLANNING FOR COMPREHENSIVE HEALTH SERVICES

Now that we have discussed federal and state planning procedures, it follows that concerted efforts should be devoted to improving the availability of health resources for the people themselves. The report of the National Commission on Community Health Services, headed by Marion Folsom, has strongly recommended as a priority item the organization and delivery of community health services by both official and voluntary agencies, based on the concept of a community solution rather than primarily on political jurisdiction. Several major efforts are being made to approach this new concept. It is axiomatic that health service boundaries of a community should be established by the area within which a problem can be defined, dealt with, and solved. We in Kentucky recently received a project grant to experiment with this approach in the Appalachian area of our state. It is understood that Virginia and West Virginia are also submitting grant requests to the Appalachian Commission to approach this similarly.

It seems that there are essentially two kinds of regionalization that must be considered. First is a community which involves a population of approximately 2-3 million and will cross state lines in some cases, and second is that which involves several small counties or communities and necessitates the combination of several resources in order to be able to adequately provide the health care that is needed.

In the first case the best example is the heart disease, cancer, and stroke amendments in 1965 which provide for a relatively large population base and is essentially centered in a medical school setting. Heart disease, cancer, and stroke are overwhelmingly the leading causes of death in the United

States today and programs designed to cope with the related problems are greatly in demand. While there are, of course, intrinsic human values in improving teaching, research and treatment of these major causes of death, the greater importance and ultimate rationale of the heart disease, cancer and stroke legislation is to promote a pattern of medical care regionalization that has long been needed by medical science in this changing society. The great challenge before us is that of developing a regionalized flow of patients and services so that optimal quality is independent of personal income and the patient's home address. It can generally be observed that even now the manifest brain tumor, the special heart surgery is nearly always referred to a major medical center for care. But in the large middle-range of conditions, such as complications of pregnancy or gastrectomy are treated by surgeons or physicians ill prepared to cope with them and in hospitals poorly equipped for the respective purposes. At the same time, those of us responsible for total health services must keep in mind the broader spectrum of program planning. Dr. G. Stickler, in a recent issue of the **American Journal of Public Health** on the subject of "What Priority Human Life?", made an important contribution. His contribution relates to the accumulation of loss of life-years and future income for selected causes of death, using the criterion of life-years lost rather than lives lost. The order of importance is (1) heart disease, (2) infant deaths, (3) stillbirths and miscarriages, (4) neoplasms, (5) accidents and other violences, (6) prematurity, (7) congenital defects, (8) stroke. Also, much has been written about the great impact that alcoholism, mental illness, arthritis, diabetes, and other debilitating diseases have had on our population. We must be concerned not to concentrate

only on heart disease, cancer, and stroke; otherwise, obstetrics, gynecology, psychiatry, practically all of pediatrics, most of surgery, and much of medicine will be excluded. However, if availability of funds restricts us to heart disease, cancer, and stroke, it would make sense to develop a general program of regionalization applied to all diseases, with heart disease, cancer, and stroke as the first phase. Otherwise, it could very well happen that patients with heart disease, cancer, and stroke will have ready access to specialized services in the teaching centers and their local physicians will be better equipped to care for them but the unfortunate individuals who contract other diseases will have no such advantage.

An example of the second kind of regionalization is that of approaching several small communities with the idea of organizing a medical complex of health professional personnel and facilities which could effectively cross political jurisdictions and also attract effective personnel to the community being considered. It is suggested that if the community (that is, the community of solution) could be provided sufficient facts, they will inevitably make the best decision. Thus far, it is apparent that they have been provided very few if any facts as to what a new community might be able to accomplish.

SYSTEMS FOR COMMUNITY HEALTH SERVICES

As far as state and local agencies are concerned, it is urged that much more concerted planning and functions are going to be required if we are to cope with the complications of evolving concepts in Medicare and Environmental Health. The current problems involving hospitalization, nursing homes, home care, water pollution, air pollution, general sanitation, and all the agencies and

individuals necessitates written plans and policies for all concerned. There must be a special concern for accountability related to evaluation. We in state and local health departments must take a bold approach in setting up specific written methodology for critical investigations of all local services being provided. There must be a new emphasis given to communications and more productive systems of gathering data and data analyses, particularly for programs conducted by local health departments. State health agencies must work with local health departments in sophisticating this total mechanism to provide for composite information for regional and state review purposes—in order that more rapid action can be realized in adopting current plans and priorities. We've all attended meetings where these matters have been discussed, and yet, to my knowledge, very few plans have reached a point of action. The pressures are so large now that we can wait no longer to cope with current and inadequate systems of providing local health services.

ENVIRONMENTAL HEALTH

Finally, probably as high a priority exists for the improvement of environ-

mental health services as any program we participate in. Personnel working in programs for the control of environmental hazards must seriously re-evaluate their activities. There is no longer a simple, single, or safe methodology or system or channel which our complex society can utilize in attacking modern community problems. This is particularly true for environmental health. To establish and maintain controls which will abate pollution and maintain quality in our environmental resources requires knowledge and use of a broad range of sciences—technical and social. Technical sciences—physical, chemical, and biological—provide the means of identifying material problems and establishing processes for their control. Similarly, social sciences—particularly political science and economics together with education—provide tools for identifying the behavioral aspects of problems and developing recognition and acceptance of controls. Achievement of desired control objectives and maintaining them at levels meeting public acceptance depend upon skillful adaptation and use of a wide range of scientific techniques.

Effective environmental program performance, then, requires not only a

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working knowledge of the wide range of sciences but developed aptitudes and skills in their application. Ultimate accomplishment in meeting environmental health objectives can scarcely be expected to outreach the "state of the art" as represented by its field of knowledge and ability of its practitioner to use it. Very important, then, is that state, regional, and local environmental personnel must think in broader concepts and be involved with more technical responsibilities.

In any regard, we in the field of providing health services are faced with a tremendous challenge for a complete rethinking in the organization of our health services. We must think in terms of melding the private and public sectors of health and medicine; we must also think in terms of melding treatment and preventive medicine in order to realize maximum results; and we must think in terms of coalescing all of our limited resources to fit the total dynamics of the current situations.

What is in the cards for the Southern Branch of APHA, the State Affiliate Societies, and the individual membership? We must develop our leadership, we must understand our problems better and develop new programs and techniques for coping with them.

We definitely must change our attitudes and our approach to meeting health problems, or these changes will come about without us. These changes are as inevitable as the changing seasons. And as President Truman observed: "If you can't stand the heat, stay out of the kitchen."

Our Southern Branch has made important strides recently with our new Executive Secreary, Mr. Frederick W. Hering and his office staff at Birmingham, Ala. Real improvements have been made during the past year in State Association - Branch relationships. The Management Institute held in Memphis,

Tenn., recently, although not attended by all affiliates, was quite successful for a first attempt.

Our Program Committee, under the leadership of Dr. Robert F. Lewis and Dr. John Neill, along with our Section Officers have done a remarkable job in providing an excellent forum at this meeting, which is part of the learning experience so necessary for us to meet the challenge facing all of us today.

At this point I want to thank all of the officers and committees for the hard work in making this meeting a step toward facing our challenge. Especially, we all owe Dr. C. A. Pigford and his Committee on Local Arrangements a vote of thanks for making our meeting in Houston so pleasant and productive.

I should like to close my remarks by posing a few questions:

Can the Southern Branch and the State Affiliate become effective action groups for progressive public health movements?

Can we develop sound policy statements that can be translated into political action when needed to promote progressive health legislation?

Can we become a medium for better communications on vital health matters?

My answer to these questions is Yes. We must emphasize professionalism. Without discounting our social activities, we cannot afford to let our meetings be just gatherings.

Let us dedicate our organizations to ACTION in implementing the vast new legislative programs, and to the support of professionalism in the public health movement in this great country.

" . . . a speech to be immortal doesn't have to be eternal."

—Muriel Humphrey

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DATES AND EVENTS

- Sept. 4-10—International Conference of Social Welfare, Washington, D. C.
Sept. 5-7 — International Conference on Water Pollution Research, Munich.
Sept. 7-9 — Conference on Service and Training—Home Health Service, Winston-Salem.
Sept. 8-10 — N. C. State Employees Convention, Jack Tar Hotel, Durham.
Sept. 15 — N. C. Rural Health Conference, Hotel Sir Walter, Raleigh.
Sept. 19-24—International Congress on Occupational Health, Vienna.
Sept. 25-29 — Water Pollution Control Federation, Kansas City, Mo.
Sept. 27-28 — American Medical Association — Council on Occupational Health, Portland, Ore.
Sept. 29 - Oct. 2 — American Medical Writer's Association, New York.
Oct. 3-5 — National Rehabilitation Association—National Conference, Denver, Colo.
Oct. 3-7 — International Clean Air Congress/International Union of Air Pollution Prevention Association, London.
Oct. 5-7 — N. C. Public Health Association,

- Robert E. Lee Hotel, Winston-Salem.
Oct. 6-7 — Invitational Conference by National Cancer Foundation on "Catastrophic Illness; Impact on Families," Biltmore Hotel, New York.
Oct. 10-15 — STATE FAIR WEEK
Oct. 13-16 — American Occupational Therapy Association, Minneapolis.
Oct. 16-18 — 19th Annual Conference on Family Life, Battery Park Hotel, Asheville.
Oct. 16-20 — American Association of Medical Record Librarians, Milwaukee.

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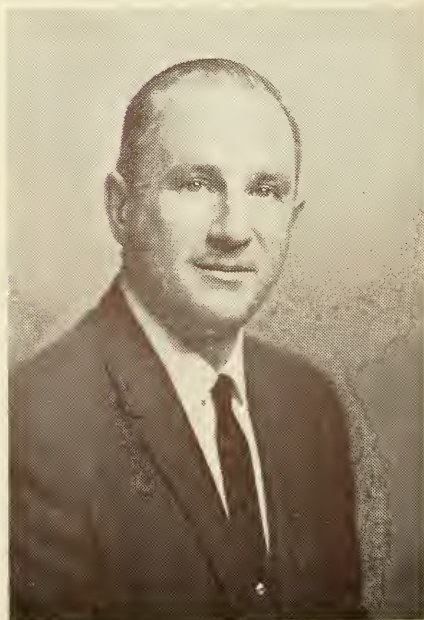
**State Board of Health
Will Stress Cleaner Air
in Exhibit at State Fair**



**James A. Graham
Commissioner
of
Agriculture**

The State Fair, October 10-15,
is a project of the
N. C. Department of Agriculture

**Arthur
K.
Pitzer
Manager of
the North Carolina
State Fair**



**Air Pollution Control
Will be the Theme
of the
State Board of Health Exhibit
at the State Fair**



AIR POLLUTION EXHIBIT - "THE TWO FACES OF CONTRASTING AIR"

Many Health Related Exhibits Will Be Seen At the Fair



The Health Bulletin

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Editor—Edwin S. Preston, M.A., LL.D.

Vol. 81 September, 1966 No. 9



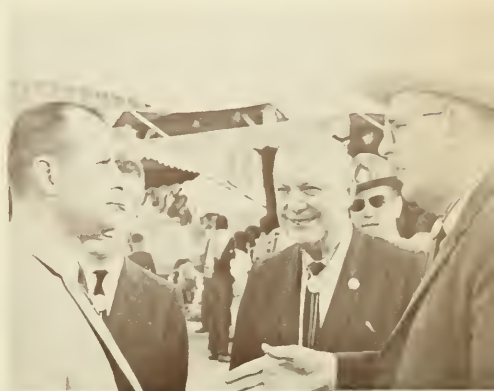
"Operation Appreciation"

The Opening Day of the State Fair Will Be Dedicated to Viet Nam Servicemen and Their Wives and Children

In a special ceremony at 10:00 a.m. Monday, October 10, the authorities of the State Fair and the leadership of the State will join in an appreciation of the servicemen who are or have been serving in Viet Nam.

Governor Dan K. Moore, Agriculture Commissioner Jim Graham, and all the concessionaires and show owners will join in having the wives and children of these servicemen as guests for the opening day of the Fair. The concessionaires include the food and drink concessions, the James E. Strates Shows, the Jack Kochman Hell Drivers and many others.

Governor Dan K. Moore, Agriculture Commissioner Jim Graham, and James E. Strates (left) plan for "Appreciation Day" for Viet Nam servicemen's families.





**Crafts
of
Many Kinds
Inspire to
Do-It-Yourself
Efforts**





**Children Go for Pleasure
and Absorb
Much in Increased Understanding**





**Products
and
Productions
Are Featured
In the Exhibits**





**Come
and
See
It
Done**







William H. Stewart, M.D., Surgeon General, Keynote Speaker at N. C. Public Health Association meeting in Winston-Salem October 5-7.

Critical Medical Supplies Are Distributed

A 30-day supply of critical medical items for disaster care will be placed in the nation's hospitals, according to Dr. Henry C. Huntley, Chief of the Division of Health Mobilization, Public Health Service.

Also, Packaged Disaster Hospitals, now stored in some 2600 locations throughout the United States, will be assigned to community hospitals.

Priority in both activities will be based upon location.

This redirection of the Emergency Medical Stockpile program comes as a result of recommendations made by the Emergency Health Preparedness Task Force after a year-long study. On the Task Force were representatives of the Bureau of the Budget, Office of Emergency Planning, Office of Civil Defense, Office of Science and Technology, and the Department of Health, Education, and Welfare, of which the Division of Health Mobilization is a component.

Any massive disaster, whether brought about by a weather catastrophe or by nuclear attack, would create a great strain on the available medical resources—to such an extent that meeting even the minimum health needs of the survivors might be extremely difficult. The Public Health Service now provides health assistance to localities stricken by disaster when requested by the State Health Department. Increased Federal assistance through the new inventory-expansion program and in the Packaged Disaster Hospital program assures maximum flexibility in making health resources available at points of greatest need as quickly as possible.

A prime advantage of the new approach is that an almost automatic rotation of limited shelf-life items can be assured. The hospital will use items supplied by the inventory expansion program in its daily operations and, at the same time, will continue its established rate of procurement. Ordinarily, a hospital seldom maintains a large inventory of expendable items because resupply is very easy. In a disaster situation, however, lines of resupply would almost certainly be disrupted and at that time the 30-day inventory provided by the Health Mobilization program would suddenly become of utmost importance.

The direct affiliation of Packaged Disaster Hospitals with existing hospitals will assure the availability of hos-

pital supplies and equipment to permit the parent hospital to greatly expand its patient-load capability or to set up a subsidiary hospital in another building should this become necessary. "This affiliation will also assure the availability of a physician to direct the use of the Packaged Disaster Hospital and will help considerably in securing sufficient additional medical personnel," Dr. Huntley noted.

Both the American Medical Association and the American Hospital Association have expressed satisfaction with the redirection of the stockpile program. The AHA will assist the Division of Health Mobilization in its hospital contacts.

Essential to the community hospitals' disaster efforts are the supporting services which are the responsibility of the Office of Civil Defense. These include provisions for a communications capability, police protection, transportation and traffic management, as well as food and laundry service for the increased patient-load. Close coordination between the local civil defense organization and the local medical community is being encouraged to assure the full-

est utilization of each Packaged Disaster Hospital and of the other medical items added in the hospital inventory expansion program.

Nine Short Courses Sponsored by National Health Council

The National Health Council, through its Committee on Continuing Education, has announced that it will sponsor nine short courses in 1966 for eligible personnel of voluntary, official and professional health agencies and organizations.

Five courses will focus on the subject of Executive Development, two on The Voluntary Health Agency in the Community, one on Program Planning for Community Health Agencies, and one course on Voluntary Health Agencies and the Schools.

The nine courses will be conducted by seven universities on various dates ranging from June through October, 1966.

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The 99th North Carolina State Fair



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DATES & EVENTS

- Oct. 3-5—National Rehabilitation Association (National Conference) Denver
- Oct. 3-7—International Clean Air Congress/International Union of Air Pollution Prevention Assn., London
- Oct. 5-7 — N. C. Public Health Association, Robert E. Lee Hotel, Winston-Salem
- Oct. 10-15—STATE FAIR WEEK
- Oct. 10-13—American Academy of General Practice, War Memorial Auditorium, Boston
- Oct. 13-16 — American Occupational Therapy Association, Minneapolis
- Oct. 14-16—National Conference on Family Life of The Methodist Church, Chicago
- Oct. 16-18—19th Annual Conference on Family Life, Battery Park Hotel, Asheville
- Oct. 16-20—American Association of Medical Record Librarians, Milwaukee
- Oct. 18-19—American Cancer Society (Annual), New York
- Oct. 18-21—Annual meeting, N. C. State Nurses' Association, Robert E. Lee Hotel, Winston-Salem, N. C.
- Oct. 20-25—American Heart Association, New York

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THE HEALTH BULLETIN

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V. 81, #10

OCTOBER 1966



Health Leaders Confer At Annual NCPHA Meeting

Dr. Frank Jones, Newton, President of the Medical Society of the State of North Carolina, confers on the platform with Dr. Jacob Koomen, State Health Director, during a General Session of the Annual Meeting of the North Carolina Public Health Association held in Winston-Salem in October. Dr. Jones delivered one of the principal addresses of the meeting.

Leaders who appeared on the program of the first General Session of the NCPHA Annual Meeting. From left, these are: Dr. J.W.R. Norton, Dr. Paul Peterson, Dr. Jacob Koomen, Mr. Robert Brown, Association President, and Dr. W. Fred Mayes.



Dr. Paul Peterson, Washington, D. C., Assistant Surgeon General, always an appreciated visitor to North Carolina, appeared on the program of the NCPHA meeting in Winston-Salem. Dr. Peterson delivered the address by Dr. William H. Stewart, Surgeon General, in the absence of Dr. Stewart who was detained at the last minute in Washington to appear before a Congressional Committee on important health legislation.

"An Invitation to Greatness"

By WILLIAM H. STEWART, M. D.

Surgeon General, Public Health Service

U. S. Department of Health, Education, and Welfare

The art of prophecy has never been easy, and its practitioners have never been noted for either longevity or tranquility. If you prophesy doom and it happens, you are blamed for it. If it doesn't happen, you are laughed at. On the other hand, if you predict sunshine and it rains, you are never forgiven by the people who planned the Lodge picnic. Even if you base your projections on solid statistical data and keen observation of trends, you may be in trouble—witness the 4th century Roman who confidently foretold an ever-increasing production of roads, aqueducts and temples while the Visigoths were gathering outside the gates.

Yet despite all this overwhelming evidence, soothsaying has an irresistible appeal for keynote speakers, commencement orators and governmental officials. Since I represent two of these three categories today, it is inevitable that I shall stick my neck out into the future. I hope everybody will take heed and nobody will take notes.

Seriously, it is very clear to anyone who sees beyond the end of his stethoscope or sliderule that the currents of the future are converging on public health. The old assumptions, the old boundary lines, even the old vocabularies are becoming less relevant with every passing year. Society expects excellence in health care, universally accessible. An invitation to greatness is being thrust upon us. If we do not accept, it may very quickly be withdrawn and thrust upon someone else.

***Keynote address at the annual meeting of the North Carolina Public Health Association, Winston-Salem, N. C. October 6, 1966.**

One of my distinguished associates in the art of prophecy, Dr. Ward Darley, for many years an outstanding spokesman for academic medicine, has recently outlined what he calls the "seven inevitables" for health and medicine. He lists them in this sequence: "(1) increasing knowledge; (2) increasing specialism; (3) increasing demands for service; (4) increasing costs of service; (5) increasing shortages of personnel; (6) increasing complexity and efficiency in data processing and communication; and (7) increasing institutionalization, or organization."

It would be hard to quarrel with Dr. Darley's declaration that these are the inevitables with which we shall have to cope, barring a world catastrophe which would be, I suppose, the 20th century equivalent of the Visigoths.

When we take the list apart, we find that three of seven inevitables for health medicine are **resources**—increased knowledge, specialism, and efficiency of communication. Two are **problems to be overcome**—increased costs and personnel shortages. **The remaining two constitute the heart of the challenge** to public health and medicine—increasing demands for service, as the goal which society asks us to meet, and increasing organization as the means for bringing our resources most effectively to bear in meeting those demands.

Let me state the proposition in a somewhat different way. Our objective, set for us by the society we serve, is to make top-quality health services accessible to all the people. We have a great deal going for us, including a wealth of new knowledge and technology. We confront difficult obstacles, including shortages and rising costs.

To my mind there is only one way to overcome the obstacles and make full use of the resources. That way is through planning, organization, and coordination of effort.

There is nothing new or startling in that statement. We have been talking about organization and coordination for years.

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Editor—Edwin S. Preston, M.A., LL.D.

Vol. 81 October, 1966 No. 10

The new elements are the urgency of need and the dimensions of coordination that today's circumstances require.

Not long ago we were talking about coordination of public health effort on a community scale. Today we are talking about coordination of the total health effort on a local, state-wide and regional scale. Moreover we are perceiving that a "total health effort" must involve many agencies and groups outside our familiar orbit.

Fortunately, in response to a surge of public demand, we are being armed with new administrative tools that open the door for this kind of collaboration. Let's examine briefly the recent avalanche of Federal health legislation in the light of this quest for coordination in health affairs.

Legislation passed in 1965 reshapes our commitment in environmental health. We have a new Clean Air Act, which sets forth patterns of action and provides new resources to deal with atmospheric pollution. We have **legislation related to the disposal of solid wastes** which gives us, for the first time, tools and resources commensurate with the size of this problem. There has been a fundamental realignment of **forces to deal with water pollution.**

Underlying all of these is a firm national declaration that the quality of living is as important as the length of life—that health is one of many valid reasons for creating better surroundings. As health officials, we have a tremendous health job to do in dealing with the environment. This task requires coordination and planning with many other agencies and interests, many of them totally outside the normal boundaries of health concern.

Legislation passed in 1965 moves the Public Health Service more vigorously into the educational preparation of physicians, dentists, public health specialists, and other health professionals. The amendments to the Health Professions Educational Assistance Act not only extend our participation but also alter it



Dr. Jacob Koomen is shown during a lull in the Banquet Session of the NC-PHA Annual Meeting. Dr. Koomen was the delightful Master of Ceremonies for this occasion which honored Dr. J. W. R. Norton. Mrs. Norton is shown at the right.

qualitatively. By providing educational support grants to schools, we shall be able to assist in improving the quality of instruction at the same time that we are helping to increase the quantity of man-power produced.

Planning and coordination are essential to all of these programs. But they are the very heart of the three major items to which I want to devote most of my time this morning. Two of these are programs stemming from last year's legislation. The third is being considered by the Congress this year.

The first of these three is the regional medical programs concept stemming from the Heart Disease, Cancer and Stroke Amendments of 1965. This program, as you know, is aimed directly at the challenge of coordination. It is designed to achieve effective organization of services, not by superimposing a new system of medical care but by providing a new kind of administrative framework within which existing agencies and practitioners can work more effectively together.

The regional medical programs concept is based on a special kind of regionalization. One of the tragedies of the contemporary medical scene has been the duplication in some areas, and the total absence in others, of complex, expensive diagnostic and treatment capability. I am talking about such things as open heart surgery, chemical therapy of leukemia, and the like. Costly equipment and teams of highly skilled people have been standing idle for lack of demand in some places, while elsewhere people are dying for want of their services.

The regional medical programs are intended to remedy this kind of situation. Each regional program will be based on a "center of excellence"—a medical school, teaching hospital or specialized facility. The program, in order to be eligible to receive a grant, must be planned with the assistance of a local advisory group which includes the public health agency, voluntary agencies, and other interested medical institutions and organizations.

Guest speakers during the Laboratory Section Luncheon at the NCPHA Annual Meeting were, from the left: Dr. George Podgorny, Winston-Salem, Chief Resident, General Surgery, N. C. Baptist Hospital and Assistant in Surgery, Faculty of Bowman Gray School of Medicine; Dr. Jacob Koomen, State Health Director; and Dr. John R. Bender, Winston-Salem physician, former Vice-President State Board of Health and winner of the 1966 Distinguished Service Citation at the NCPHA Annual Meeting.



The keynote is flexibility for local determination. The essential element for the success of each regional program is solid collaboration, broadly based. The Federal participation is designed chiefly to furnish a stimulus, an incentive, for making full use of existing medical resources and for augmenting those resources where a demonstrable need exists.

What constitutes a region? Here again, the law is highly flexible. In some places a region—for purposes of program development—will consist of parts of or a single metropolitan area. In others, a "region" may be a single state. In still others, a region may encompass all or parts of several states. The criterion here is pragmatic—what constitutes a workable region in terms of the delivery of needed services. One thing that is definitely **not** intended is that each medical school should become the center of its own regional program, in competition with its neighbors.

Your planning here in North Carolina has demonstrated a clear understanding of these principles. Among other things, I am happy to note that your School of Public Health and public health agencies are active participants, vigorously involved. I hope that many more states will follow your lead.

The second major responsibility for planning and coordination vested in us by recent legislation relates to the Social Security Amendments of 1965. These include both the Title 18 program—Medicare—and the Title 19 program whose great potentiality is now capturing the spotlight previously directed at Medicare itself.

With regard to Medicare, the past is strictly prologue. The central fact is that the program is underway. Its successful beginning is a tribute to the dedication and hard work—above and beyond the normal call of duty—of thousands of people in hospitals, in governmental agencies at all levels, and elsewhere throughout the health care system.

Keeping it going smoothly will require still more dedication and hard work. We have another, and in many ways a tougher, deadline to meet on January 1 when the Extended Care Facility benefits take effect. There will be local problems and temporary crises—no national program of such scope can possibly be immune to them. But I am full of confidence that the steps now taken will never be retraced. Moreover, I believe that these steps will lead to better health care for all the American people.

For Title 18 is more than just a financing mechanism. The totality of the program—including both Parts A and B—allows "continuity of care" to become more than a pious aspiration. The private physician has opportunities long denied him by circumstances to prescribe in terms of patient need. He need no longer be fettered by family economics. The community has

(Continued on Page 13)

Banquet Scene in 1966 Annual Meeting of N. C. Public Health Association Honoring Dr. J. W. Roy Norton

**First Annual Meeting Following Dr. Norton's
Relinquishment of State Health Directorship
Honors His Nearly 18 Years of Service In That Position**



Distinguished Roster of Guests at the Head Table Led in an Enjoyable Evening Program

The Head Table Personnel from the left: Jane Wentworth, Retiring NCPHA Secretary; Mrs. James A. Finger; Dr. James A. Finger, Chairman Local Arrangements; Mrs. Annie B. Edwards; Dr. Jacob Koomen, Master of Ceremonies; Mrs. J. W. R. Norton Dr. J. W. Roy Norton; Mr. Robert Brown, NCPHA President; Mrs. Corinna Sutton, Incoming President of NCPHA; Dr. W. Fred Mayes, Chairman of Awards Committee; Mrs. W. Fred Mayes; Dr. Maurice Kamp, President-Elect; Mr. Scott Venable, Vice President; Dr. George G. Dudney; Mrs. Mildred Kerbaugh, NCPHA Treasurer; and Miss Lydia Holley, Incoming Secretary NCPHA.



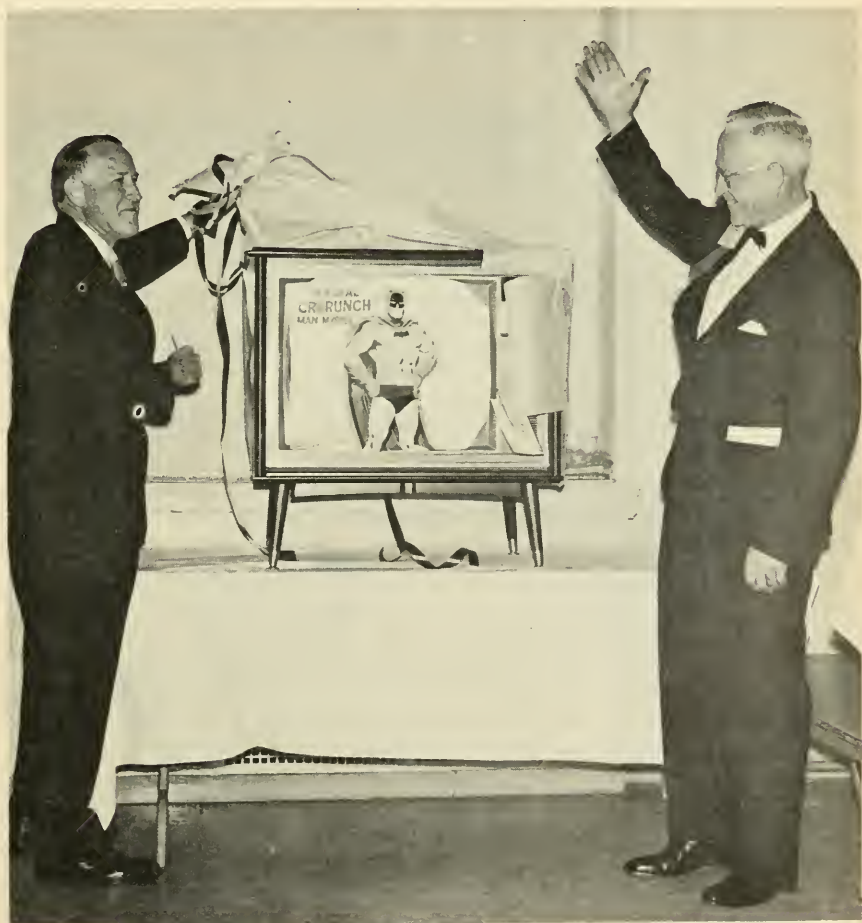
Dr. J. W. Roy Norton Responds To Presentation



**The North Carolina
Public Health Association
Presented Dr. Norton
With An RCA Color
Television Console
As An Expression of
Appreciation For The
Nearly 18 Years of
Service He Has Given
As State Health Director**

The Gift

Mr. Ben Eaton Unveils the Color Television Set and Makes the Presentation for the Association. (Mr. Eaton said that Dr. Norton's favorite (?) program was in progress)



A Delightful Surprise

During the Banquet Mrs. Annie B. Edwards was recognized and presented a Framed Picture showing the Four State Health Directors with whom she has served as secretary. Mrs. Edwards' picture is inset amongst the pictures of the following State Health Directors: Dr. Charles O'H. Laughinghouse, 1926-1930; Dr. James M. Parrott, July 1, 1931 - Nov. 7, 1934; Dr. Carl V. Reynolds, Nov. 10, 1934 - June 30, 1948; and Dr. J. W. R. Norton, July 1, 1948 - Dec. 31, 1965.



the opportunity to develop a truly comprehensive system of quality medical service; for full-cost reimbursement means that the Social Security Insurance System is willing to pay for quality. In a sense, this legislation underwrites the development of quality services. Further, through the utilization review process, the legislation provides a means for assuring that our resources are used with maximum effectiveness in meeting patients' needs.

As for the public health profession, this can be our finest hour. If we discharge our responsibilities at the top of our form, with the top-level professional competence of which we are capable, we shall earn and receive the highest expressions of honor and gratitude from the American people.

Title 19 of the Social Security Amendments, in effect, pulls together under a single formula the various medical assistance programs related to public assistance and includes the people now covered by the Kerr-Mills program. Its intent is clear: to develop a program of comprehensive, high-quality medical services for substantial segments of our population. Despite great efforts and outstanding performance in some places, such a program has not existed for public assistance beneficiaries up to this time.

Clearly there are implications of great significance for the health professions in this undertaking. A tremendous amount of coordinating will have to be done. If the Title 19 program is carried out as its separate components have been in the past, it will fall far short of its promise as a means of assuring quality comprehensive care for its beneficiaries. We are dealing here with a new, bold approach to the age-old problem of providing medical care for the disadvantaged by integrating such care into the mainstream of community medical service.

Finally, I want to direct your attention to legislation now before the Congress, the Partnership for Health Act proposed in Senate Bill 3008. The Bill embodies the results of a long-overdue study in depth of the principles involved in Federal grants for health programs and the impact of these grant programs on the States and communities.

You are aware, I am sure, of the reasons for such a study. Over the past several years, Federal grant programs have multiplied many-fold. Many of these programs have been administered by the Public Health Service; others, related directly or indirectly to health, have been the responsibility of other Federal agencies.

The result has not been total chaos, thanks to competence and diligence on both ends of the pipeline. But the process has led to fragmentation, to duplication in some fields and gaps in others. We in the Federal government have been asking you, in the States and communities, to assume large new functions and have given you funds specifically earmarked

for each task. No one has been charged with relating the parts to the whole. We have proceeded largely along categorical lines, ignoring the fact that many of the dominant health problems of today do not lend themselves to this approach.

These two elements—proliferation of fragmented programs and the problem of the categorical approach—were uppermost in our minds as we tried to devise a new and more productive pattern of Federal-State grant relationships. To these I would add a third, closely related to the others—the need for greater flexibility in the use of Federal resources to meet the special problems of the various states. These are concepts that went into the preparation of the Partnership for Health Act, now before the Congress with the sponsorship of the Administration.

In summary, the keynote of the future is organization and coordination— across community lines, across disciplinary lines, across both formal and informal lines of jurisdiction handed down from a less complex, less demanding past. He who hesitates to enter into these partnerships—for whatever reason— may well be bypassed by the future.

You in North Carolina have an enviable heritage of collaboration. Your Research Triangle is a symbol of combining resources for mutual advance. Your history of regional leadership in education, health and social change is well recognized throughout the Southeast and elsewhere. Your quickness to capture the spirit of new experiments in partnership—as evidenced in the regional medical programs—is rich in promise for the future.

These things give me confidence that you will accept the invitation to greatness which public expectation has offered to the health professions.

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Theodore D. Scurletis, M.D.	<i>Acting Director, Personal Health Division</i>



BEN EATON

Director, Administrative Services Division State Board of Health, who is serving as Chairman for the Meeting of the Business Management Association of Public Health to be held in the Blockade Runner, Wrightsville Beach, Nov. 9-11. Dr. Carruth J. Wagner, Assistant Surgeon General, will head a list of outstanding speakers for this important constructive meeting.

The Governor's Conference on Child Abuse will be held at the Hotel Sir Walter in Raleigh November 22. Conference Chairman is T. D. Scurletis, M.D., Acting Director of the Personal Health Division of the State Board of Health. The conference is sponsored by the Coordinating Committee on Children With Special Needs of the N. C. Health Council. Co-Sponsoring Agencies include: the State Board of Health; N. C. Council on Mental Retardation; N. C. Department of Public Instruction; and the N. C. Department of Public Welfare; N. C. Department of Mental Health.

The N. C. Health Council will hold its annual meeting Tuesday, December 6, at Jack Tar Hotel in Durham.

1966 Annual Meeting North Carolina Public Health Association Winston-Salem, Oct. 5 - 7

Attendance—850

Officers—Mrs. Corrina Sutton, President; Dr. Maurice Kamp, President-elect; Mr. C. Scott Venable, Vice-president; Miss Lydia Holley, Secretary; and Mrs. Mildred Kerbaugh, Treasurer.

1966 AWARDS

Carl V. Reynolds Award—to individual NCPHA member who made greatest contribution to Public Health in North Carolina during past year—Miss Sallie J. Mooring, Nutrition Section, State Board of Health.

Group Merit Award—for outstanding cooperation and service to Public Health in North Carolina during past year — Halifax County Health Department.

Watson S. Rankin Award—to individual for long and faithful service to public health in North Carolina—Dr. Otis Ladeau Ader, Durham, Director Durham County Health Department; and Dr. John J. Wright, Chapel Hill, School of Public Health, University of North Carolina.

Merit Citation — to individual members of NCPHA who have been doing outstanding work—Mr. Rollin Wilson Johnson, Iredell County Health Department; and Mr. William M. Haislip, Gaston County Health Department.

Distinguished Service Citation—to individual non-members of NCPHA for outstanding service to Public Health in North Carolina—Dr. John R. Bender, Winston-Salem Physician and former Vice-President of the State Board of Health.

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DATES & EVENTS

- Nov. 6 - 9 — Medical Society of Virginia, Williamsburg, Va.
Nov. 6 - 14 — World Medical Association, Manila
Nov. 10 - 13 — National Society for Crippled Children and Adults, Annual Meeting, Penn-Sheraton Hotel, Pittsburgh
Nov. 8 - 10 — Annual Meeting: Public Health Nursing Supervisors' Conference, Chapel Hill
Nov. 9 - 11 — Business Managers' Association of Public Health, Blockade Runner, Wrightsville Beach.
Nov. 9 - 11 — Public Relations Society of America, New York Hilton Hotel, New York
Nov. 11 - 16 — National Society for Crippled Children and Adults, Pittsburgh
Nov. 13 - 24 — NATIONAL RETARDED CHILDREN'S WEEK
Nov. 14 - 16 — American Association of Homes for the Aging, Milwaukee
Nov. 14 - 19 — National Association for Mental Health, New Orleans
Nov. 14 - 17 — American Dental Association, Dallas

- Nov. 14 - 17 — Southern Medical Association, Washington Hilton Hotel, Washington, D. C.
Nov. 17 — National Society for the Prevention of Blindness, New York
Nov. 19 - 22 — American Speech & Hearing Association, Washington, D. C.
Nov. 28 - 30 — Association of Rehabilitation Centers, Warwick Hotel, Philadelphia
Nov. 29 - 30 — Local Health Directors, Institute of Government, Chapel Hill.

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81, #11 (Nov. 1966)



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health



John W. Gardner, Ph.D.

Dr. Gardner is Secretary of the Department of Health, Education and Welfare. See his profile on pages 10 and 11.



Mrs. C. Gordon Maddrey, 1966 Christmas Seal Chairman, visits a student (top picture) being instructed by the Board of Education while being treated for tuberculosis. In the bottom picture Mrs. Maddrey visits a classroom of young patients in the tuberculosis hospital at McCain.



The Tuberculosis Association Considers Regionalization of Its Health Services

by W. H. Gentry, M.D.

President, North Carolina Tuberculosis Association

W. H. Gentry, M.D.



The 1965-66 Annual Report of the North Carolina Tuberculosis Association dealt at length with organization—organization past, present and future.

At the present time organization is uppermost in the minds of all tuberculosis associations in the state and rightly so. The Qualifications and Contract Committee of the State Association, after lengthy and careful deliberation, has recommended the merger of all counties to form 10 area associations in the state. The consensus of the Committee was that "The structure of the association must change to keep pace with rapid advances in our modern society. Programs must be more effective. Local associations must be stronger and staffed by qualified trained personnel. Budgets must be larger. The State Association must be strong and adequately financed. Medical education and research programs in North Carolina must be continued and strengthened."

Historically, special emphasis was put upon organizing local units in each of the principal towns of the state. The movement led by physicians was unusually successful and reached a peak in 1937 with 270 small local organizations scattered throughout the 100 counties.

Then came a change of emphasis. The organizational trend initiated in 1941 was to consolidate multiple units in a county into a single county unit. This was followed by the merger of counties to form district and area associations.

All of these actions have been taken with one idea in mind; namely, to form the kind of structure in which the functions of a voluntary tuberculosis association could best be carried out.

As far back as 1951 a study of the organization and program of the North Carolina Tuberculosis Association was made by a team of the National Tuberculosis Association's staff in 1951. Among the recommendations of this team were two regarding organization.

1. "That the state association's primary efforts in local organization be directed toward the counties of 50,000 or more population; and in those areas where district organizations could be established.

2. "That an aggressive program of district organization be pursued in accordance with the then proposed official health district plan. This took place fifteen years ago."

Another activity which focused attention on organization was the exploratory study of voluntary health and welfare agencies in the United States financed by the Rockefeller Foundation directed by Robert Hamlin, M.D. In his discussion of the study he made certain pointed observations

"Voluntary agencies provide a principal means through which private citizens may act for the betterment of their nation, their communities and their fellow man. Whether the altruistic goals of millions of private contributors and volunteers are realized depends therefore, to an important degree upon the quality of agencies."

Continuing, he declared:

"When viewed from the proper perspective of the general health and welfare of the nation, the machinery of many voluntary agencies has unfortunately become inefficient and at times jealously self-centered. This antiquated machinery seriously im-

pairs the capacity of the agencies to carry modern day responsibilities.

"One major difficulty of national voluntary agencies has been their inability to terminate, modify or consolidate local affiliates when a better organizational structure with increased effectiveness in the public interest would result. The predominant desire of the affiliates too frequently is for self-perpetuation to the detriment of over riding public interest."

And finally:

"My greatest concern is not with the program of the National Tuberculosis Association and its affiliates. It is with their **inadequate organizational structure**. My plea is that you give as much emphasis to modernizing your organizational structure as you do to the commendable redefining

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Editor—Edwin S. Preston, M.A., LL.D.

Vol. 81 November, 1966 No. 11



Mrs. W. Gordon Maddrey
1966 Christmas Seal Chairman

of your program objectives. One without the other is not only insufficient, it also invites failure, or at least limited success."

Even before Dr. Hamlin made his report in 1961 the National Tuberculosis Association's Committee on Organizational Structure had considered this problem of organization and had reviewed financial reports available for 2,711 local affiliates. Of these, 1,127 received less than \$1,000 for local operations. Another 980 received between \$1,000 and \$5,000. It found that only

558 organized local associations employed full-time professional staff. It was the committee's belief that many of the existing local affiliates were not in a position to conduct suitable programs.

The late Dr. Howard Payne, Superintendent of the Middlesex County Sanatorium, NTA board member and an instructor in medicine at Harvard Medical School commented thusly:

"An Association that cannot compete in the market place for skilled professionals to carry out programs will do much better to combine into a larger unit with a stronger economic potential and, therefore, better programs . . . The volunteer board needs to compete for and pay adequately the skilled professional help to do the job."

Significantly, here in North Carolina the board of directors of the State Association has recognized the need for improving organizational structure, and for more than twenty-five years this state has been moving in the direction of consolidation.

Critics of the reorganization movement will call it an effort to thwart local autonomy. Multi-county units can verify that nothing is farther from the truth. Boards of directors in district and area associations are elected from each of the counties involved and they set the policies for the organization, as always, within a framework of approved principles for tuberculosis associations.

Existing multi-county units and their pattern of operation must share a part of the credit for the recent recommendation of the Qualifications and Contract Committee of the state association.

The Committee concluded that regionalization of its health services would strengthen the entire tuberculosis association's movement.

Tuberculosis In North Carolina

by R. V. Berry, M.D.

Chief of the Tuberculosis Control Section, N. C. State Board of Health

During 1965, 944 new active cases of pulmonary tuberculosis (excluding 167 cases of primary tuberculosis) were reported from all sources in North Carolina. These were almost all adults. This figure has been remarkably constant over the last 5 years or so. Some 72% of the reinfection-type pulmonary cases reported in 1965 were either moderately or far advanced, rather over half being in the latter category.

Epidemiologically, some three-fourths of these new active pulmonary cases are thought to occur as a result of endogenous breakdown from infections acquired earlier in life. Such persons can be identified by means of the tuberculin skin test. Perhaps about one fifth of the adult population have been thus infected and are potentially liable to suffer endogenous breakdown into clinically active disease. These are the people that should be under surveillance by means of periodic chest X-rays.

The other approach that may help to lead us on the path towards eventual elimination of the disease is the childhood approach involving the identification of young people (under 7 years) who have had the misfortune to have

become infected, as evidenced by a positive tuberculin reaction. The close contacts of these children can be examined in an attempt to find the source of the child's infection and by bringing such source case to treatment, prevent the infection of other children in the family. It goes almost without saying the close contacts of a new active case found by whatever means should be considered for prophylactic treatment, particularly if they are very young (under 5 years of age). Clinicians, epidemiologists, and public health workers are becoming increasingly aware of humans becoming infected with atypical mycobacteria, which infection has a rather different natural history (incompletely worked out). Such infection may produce some immunity to the usual type of tuberculosis and may be confused with it due to cross-reaction with PPS-S. These atypical mycobacteria are widely distributed in the S-E. United States and the differential diagnosis between them and infection or disease caused by *M. tuberculosis* requires careful evaluation in all phases of tuberculosis control work.

Surgeon General Announces New PHS Organization

William H. Stewart, Surgeon General of the Public Health Service, has announced a new organization plan of the Public Health Service with the approval of John W. Gardner, Secretary of the Department of Health, Education, and Welfare.

The reorganization replaces the three-bureau structure which has been in effect since 1944. The Secretary, who earlier approved an overall five-bureau structure for the PHS, accepted the more detailed plan prepared by the Surgeon General assigning the existing and new Divisions of the Service within the five Bureaus. (Proposed Organization of PHS shown on chart on pages 8-9.)

The National Institutes of Health, one of the five Bureaus, is the primary biomedical research arm of the Federal Government. The NIH will be augmented by the addition of a new Division of Environmental Health Sciences to foster research on environmental threats to health.

The other Bureaus are: The Bureau of Health Services, Bureau of Health Manpower, Bureau of Disease Prevention and Environmental Control, and the National Institute of Mental Health.

Coordinating and directing these programs, and setting overall policy for the public Health Service, will be an expanded Office of the Surgeon General. Directly related to the Office of the Surgeon General, but with independent status, are the National Library of Medicine and the National Center for Health Statistics. The new organization plan will be in effect on or about January 1, 1967.

(See chart on pages 8 and 9)

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Contemporaries

John W. Gardner, Ph.D.

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The Department of Health, Education, and Welfare had the reputation of being the executive branch's "Austro-Hungarian Empire"—a confederation of bureaucratic baronies beset by outside pressures and overwhelmed by wide-ranging responsibilities. A former HEW secretary said it was unmanageable and should be broken up. Logically, the tide of 1965 legislation including Medicare, aid to education, and expanded medical assistance should have exploded HEW. Yet today, with nearly 100,000 employees and expenditures of \$37 billion annually, talk of HEW's "dissolution" has itself dissolved. Why? In large measure, the answer is a man: John W. Gardner.

The 54-year-old social psychologist accepted a Presidential mandate in July 1965 to remedy HEW's ills. He approached the task in the belief that though HEW need not be ungainly, it must be complex. "Ours is a big and complex society, and its needs—including the needs of individuals—are going to be served by big and complex institutions—whether government agencies or corporations or universities," Mr. Gardner says. "The whole movement of events in recent years has been not toward separation but toward the interweaving of the department's various objectives," he adds. "Whatever it is that makes a person less than he could be is a matter of concern to HEW."

Working with fresh authority from Congress, Mr. Gardner built an expanded layer of assistant secretaries into top HEW management. Their job is to advise and coordinate approaches to the problems criss-crossing among major agencies and bureaus. Thus, Medicare—though run by the Social Security Administration—has policies devised with the help of the Public Health Service and the Welfare Administration; all this is coordinated through the assistant secretary for health and scientific affairs. At the same level as the assistant secretaries are a general counsel, a comptroller, and a special assistant for civil rights. Led by an undersecretary, this squadron of executives helps discharge Mr. Gardner's most important responsibility: "To assure that the new and expanded programs are functioning smoothly and effectively."

Before he used this remarkable opportunity to remake the department, Mr. Gardner was perhaps best known in education. A graduate of Stanford University in 1935, he received a doctorate from the University of California in 1938 and taught psychology at Connecticut and Mount Holyoke colleges until the United States entered World War II, which he spent first in foreign broadcast intelligence for the Federal Communications Commission and then as a Marine officer assigned to the Office of Strategic Services in Europe. After the war, he joined the Carnegie Corporation. The National Academy of Sciences, honoring Mr. Gardner recently "for eminence in the application of science to the public welfare," noted that his writings and works during the past decade had given impetus to a revolution in education. As head of the Carnegie Corporation of New York and the Carnegie Foundation for the Advancement of Teaching, he administered grants of more than \$100 million. His reports and books—including **Self-Renewal: The Individual and the Innovative Society**—and his service to three Presidents made him a logical choice as chairman of the 1965 White House Conference on Education. Soon after, President Johnson named the Los Angeles native to the Cabinet.

Mr. Gardner feels that the health industry is essential to accomplishing certain shared purposes of the American people. An alliance between doctors, for example, and government is emerging, and success depends on both governmental resources and professional ability and integrity. The advisory councils of the National Institutes of Health provide a fascinating example of federal-nonfederal partnerships. "Today the whole health field is alive with change and growth and new ways of thinking about things," he says. "Out of that will come new patterns for the delivery of health services, and health activities in this country may look very, very different."

North Carolina Family Life Council Holds Successful Conference

Annual Conference Leaders

Program leaders at the successful Conference on the Family held last month in Asheville are, from left: Dr. Lester D. Keasey of Lenoir-Rhyne College, program chairman; Dr. Evelyn Duvall of Chicago, author and lecturer and conference keynote speaker; and Dr. Carlton Watkins, Charlotte pediatrician, Council president.





Leaders in the National Conference on Family Relations attend State Conference. From the left, Dr. and Mrs. Clark Vincent, Winston-Salem; Dr. Mildred Morgan, Black Mountain; and Mrs. V. W. (Ruth) Jewson, Minneapolis, Minn., executive secretary of the National Conference. Dr. Vincent and Dr. Morgan are past national presidents.

Some other leaders in Family Life Conference. From the left, Mrs. Stanley Atkins, chairman, Host Committee; Mrs. L. E. Metcalf, general chairman, Local Arrangements; and Miss Grace Daniel, health educator, State Board of Health.



Dr. and Mrs. George Douglas of East Carolina College, with Dr. Evelyn Duvall at the Family Life Conference.

Title XIX and the Administration of Health Services

A VARIETY of official agencies become involved with health activities at almost any level of government. It follows that coordination of many different roles and many different objectives will be a fundamental operational problem. This coordination obviously must cope with the need for taking into account the many other factors besides health which come into play in almost any given sphere of activity. These factors often overlap each other in contrasting dimension. For example, the state welfare agency, by its very nature, has responsibility for the total program of care for the poor, involving many other things beside health. The agency is responsible for providing food, housing, clothing, and other necessities of life, all of which have a bearing on the costs of medical care. The health agency, on the other hand, has what might be thought of as a perpendicular overlap, since, in contrast to the welfare agency's responsi-

bility for all aspects of the care of one group of the population, the indigent, the health agency has responsibility for one aspect of the care, health, of all of the population. Similarly, the educational agency feels a broad responsibility for children of school age, including concern for their health, while, again, the health agency looks at the health of school children as one aspect of the health of the total population. And departments of natural resources look upon public health considerations as only one aspect of the influence of the environment on human welfare, even though health professionals, not surprisingly, believe health to be the prime factor in planning control of the environment.

These overlaps, unfortunately, provide an inviting setting for jurisdictional rivalries and competition leading to further fragmentation of health services. The advent of Title XIX of the Social Security Amendments of 1965 should be mitigating rather than aggravating this dispersal of health efforts. But it is not always having that intended effect. For example, the state of Michigan has carried on an outstanding program for the care of crip-

Editorial from *American Journal of Public Health*, September 1966.

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pled children ever since the original passage of the Social Security Act. Until a recent constitutional change, the crippled children's service was an independent one which also had responsibility for a state program for the care of "Afflicted Children," defined as indigent persons under 21 needing hospitalization. Always closely related to health department activities, under the new constitution the Crippled Children's Service is now in the health department as an integral unit. Introduction, however, of new administrative norms in relation to the administration of Title XIX has already caused serious disturbance.

The explanation is not complicated. Title XIX provides that the governor shall designate a single state agency for administration of the program of medical care for the indigent and that agency not only handles the federal grant funds but receives a greater share for administrative costs if it handles them directly. Because of the resultant considerable financial advantage, the Afflicted Children's program has already been transferred to the Department of Social Services, the agency handling the general medical care for the indigent under Title XIX. This action has separated the previous Crippled Children's services and if, as is quite possible, the latter is also transferred because of the financial gain, both will be divorced from the ongoing programs of the Department of Health and the special knowledge of disease detection, case finding, management, and prevention which that department has.

It may well be that standards of care can be raised to equal levels under administration by the Department of Social Services, for the department has well-motivated competent people and they certainly would not wish to compromise their program goals through

rendering less than adequate medical care.

On the other hand, in order to do this, there needs to be gathered in the Department of Social Services a considerable amount of medical know-how which did not exist previously, embracing scope of services to be rendered, standards of care, and facilities to be used in related technical matters. As a matter of fact, the deputy director of the State Department of Public Health has already been recruited to set up a medical care unit in the Department of Social Services. This would appear to be a duplication encouraged by the letter of the law at the expense of the spirit of the legislation.

There is, of course, a general policy that coordination in operation must exist at the level of operation and can hardly be forced from above. At the same time, it is incumbent upon federal legislation and federal regulations to encourage rather than to make more difficult such coordination. There is no question that the state health agency must maintain medical competence to discharge its many other responsibilities for protecting the people's health. A simple and practical solution would be to encourage, in states where the welfare agency has been given the total responsibility for Title XIX, the contracting of responsibility for medical care with the state health agency. This, in fact, is the way it is being done in the state of Kentucky, and a recent order from the governor of Massachusetts has essentially followed these principles. The major obstacle, however, is that most state welfare agencies are interpreting directives received from the federal Welfare Administration as preventing or, at the very least, discouraging such contracting.

The very reasons, competence and experience, for the legislative insistence

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that the welfare agency be mandatorily responsible for determining eligibility of persons to be covered under Title XIX, makes it vital to take advantage of health department expertise in medical care.

In the absence of congressional direction to this effect, there is grave danger that one of the effects of Title XIX will be further fragmentation of health services. This would aggravate an already serious condition and be directly contrary to the will of Congress, as expressed very clearly in the fact that the passage of Title XIX aimed to correct the inequities, lack of uniformity, and imbalance existing among the five medical care programs now pulled together under Title XIX.

(The Journal is indebted for the above editorial to Myron E. Wegman, M.D., dean, School of Public Health, University of Michigan, Ann Arbor, Mich.)

DATES AND EVENTS

December 13—N. C. State Board of Health Board Meeting, Raleigh, N. C.
December 16-18—American Psychoanalytic Association, New York

December 26-31—American Association for the Advancement of Science, Washington, D. C.
December 26-31—American Society of Zoologists/American Association for the Advancement of Science, Washington, D. C.
December 26-31—Ecological Society of America, Washington, D. C.

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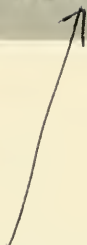
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THE HEALTH BULLETIN

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North Carolina's Itinerant Psychiatrist

(See page 3)

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Medicenter to Lower Hospital Costs

Boston University Medical Center has signed a contract with Medicenters for the construction of a "halfway hospital" for minimal care patients at the center. Room rates will be from fifteen to twenty dollars a day, as compared with the University Hospital rates of from forty-five to fifty-seven dollars.

Medicenters has largely the same management as the Holiday Inns motel chain, which, through its subsidiaries, Merchants Hotel Supplies and Innkeepers of America, handles its own operating supplies, construction materials and furnishings. With the completion of the Boston University facility next year, there will be seven Medicenters in existence. By affiliating itself with a major teaching hospital in one of the leading medical communities in the world, however, the corporation is establishing a new pattern.

Motel-type conveniences will be provided for patients whose condition does not warrant intensive care but does deserve devotion and attention. Those recuperating from surgery or serious illness will be transferred from the University Hospital to the Medicenter while those requiring diagnosis or awaiting surgery will begin their stay in the Medicenter prior to actual hospital admission. Non-professional personnel will be supervised and directed by professionals. A special training school will be conducted for employees. Additionally, the Holiday Inns employee ownership, option and profit participation program will be followed with Medicenter employees.

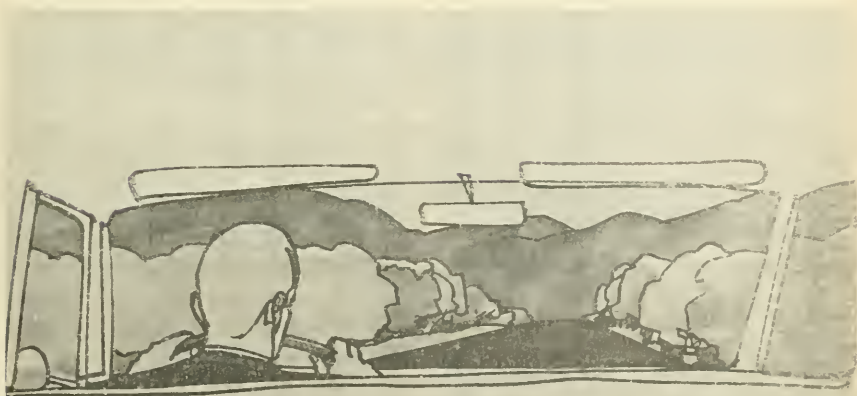
The profit motive is the backbone of Medicenters. This, coupled with the pressure inherent in any public service of this size, will provide convalescent and geriatric patients with the best care at the lowest possible cost. It will also place a high demand on any nursing home operation to maintain comparable standards to compete, all to the advantage of the patient.

North Carolina's Itinerant Psychiatrist

Used by Permission, SK and F Psychiatric Reporter, published by Smith, Kline and French Laboratories.

Where can a family physician turn for advice on treating patients with comparatively minor psychiatric disorders? Not to a psychiatrist, according to many doctors polled by Dr. Robert S. Garber a few years ago. (Psychiatric Reporter, January-February, 1963.) Such advice is hard to come by, especially for those who live far from large cities.

But the problem seems to have been solved by at least one rural area: the five counties of Allegheny, Avery, Burke, Caldwell, and Watauga in the Blue Ridge Mountains of western North Carolina. There the population of 140,000 is served by 68 physicians, none of them psychiatrists. Sixty-four of them, however, are participating in a pilot project that, since 1964, has provided them with opportunities for psychiatric consultation most GPs can only dream of. And it's all free. Once or twice a month Dr. James L. Cathell, the state mental health department's Psychiatric Consultant to Local Physicians, visits each one to discuss any case he may be able to help with. (There have been nearly 2000 in the past two



years.) Doctor Cathell is also on call between visits to help handle emergencies.

But he provides much more than advice, as I learned one day not long ago when I accompanied him on his rounds. To a surprising extent, he has also been able to mobilize community services to support the project.

"What we're trying to do in North Carolina is not really new," he told me as we drove north from Hickory Airport through rolling farmland toward the small town of Hudson. "You're already written about Hans Huessy in Vermont. [Psychiatric Reporter, March - April, 1962.] Then there's Beverly Mead in Kentucky, and Frank Kistler in Minnesota. All have published reports of similar work, and all agree that this is the least expensive way to treat mental illness. And they're right, judging from the number of people we've been able to keep out of Broughton, our state hospital. In two years, admission rates from my five counties have dropped 25 per cent. When you realize it costs the state at least \$1200—that's a conservative estimate—every time a patient is admitted, you can see why the Department of Mental Health is enthusiastic about this program. But that's only one benefit. I believe we're improving our care of mild psychiatric illness too."

We had arrived in Hudson, where one of the participants in the program, Dr. Paul Moss, has a busy general practice. Although his waiting room was filled with mothers trying unsuccessfully to keep their children quiet, he seemed happy to see us. Without preamble, he launched into a discussion of a problem patient: "I've been waiting to talk to you about this young woman I'm treating who has an alcoholic husband. She's in her early 30's, and she's always been strongly oppos-

ed to drink. Right after they were married, her husband began to drink more and more. She wouldn't have anything to do with him, began sleeping in a different room, wouldn't let him near her. She says he makes good money but she never sees any of it and has had to go to work to support the children. Well, she's a quiet-natured type of girl. She held this thing in and let it build up. Then, three months ago, she cut her wrists. I had her in the hospital, and when her husband saw how bad she was, he said he'd quit drinking. After she got out, she seemed all right until he started drinking again. Since then, every once in a while she blanks out—just doesn't realize where she is."

Dr. Cathell asked about the husband. Dr. Moss said his drinking hadn't gotten him into trouble on the job or elsewhere. When he got drunk, he was

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sometimes a little rough with his wife, but neither his drunkenness nor violence has been enough to justify putting him in jail or a mental hospital.

"I could talk to him, but he'd only deny all this," said Dr. Cathell. "If I faced him with it, he'd just get mad."

"That's about the way I size it up too," said Dr. Moss. "Their relationship just isn't close enough for her to be able to do anything with him. And she says she can't leave him because she has to take care of the children—they're all under school age. She believes it would solve all her problems if he would just pack up and leave. He won't though. Tells her it's all her fault, and this shakes her up."

"Sounds like hysteria," said Dr. Cathell. "When she's out of contact—when she doesn't remember what she's done—this is probably a hysterical or fugue-like state. And she's probably using it to try to control him. It's a hell of a combination, a hysterical woman and an alcoholic man." He paused for a moment. "Do you think she might be in a real depression?"

"No. I think there's some, but . . ."

"But more fear than anything else," surmised Dr. Cathell. "Her wrist-cutting is a touch of attention-getting. Of course, occasionally people who do this slip up and really kill themselves; so I wouldn't take that too lightly. But I get the impression hysteria is the main problem. There's really nothing you can do but give her support until she decides what she is going to do. That's all I can think of except I'd be glad to see her. It probably wouldn't be of any advantage . . ."

"I believe it would," said Dr. Moss. "I've talked with her about this problem for so long—even before this happened—over and over."

After arranging an appointment to see the young woman, Dr. Cathell turned to me. "This is a one-shot deal. If

I were to go on seeing her, it would weaken the relationship Dr. Moss has established."

Dr. Moss said, "But even though Dr. Cathell spends only a few minutes with her, she'll come back to me with a renewed attitude. These chronic patients get in a rut, lose hope. A few minutes with a specialist can make a lot of difference."

Outside, Dr. Cathell remarked that often after a patient talks to a psychiatrist the family physician's attitude toward therapy changes too; he proceeds with more assurance and enthusiasm. "Partly because I can usually provide him with a realistic prognosis. So many people have oversold psychiatry that the general physician often expects too much. He feels better after he realizes that, just as with diabetes and many other diseases, all he can usually give is supportive therapy. Of course, I can sometimes help him understand the patient better, and that helps too."

As we drove away Dr. Cathell was saying, "You know, actually the most valuable asset we have in this program is our Public Health nurses. They can do much more with these mountain people than anybody else. We'll visit a crackerjack nurse this afternoon. She goes up into those mountain coves—may take her all day to get to the house—but she gets to all of them over a six-month period. Mention any family in the county and she's got the whole background on them."

During our next visit, in the resort town of Blowing Rock, I was to see convincing evidence of the way Dr. Cathell was able to use the help of Public Health nurses. At Blowing Rock Medical Clinic, we met Drs. Lynn D. George and Lawrence A. Heavrin. On a previous visit they had asked Dr. Cathell to see a severely disturbed 13-year-old girl who refused to attend

school.

Now Dr. Cathell was able to report: "What I think we're seeing here is an autistic reaction—a schizophrenic withdrawal, if you want to call it that. You know that her oldest brother has epilepsy?"

"Yes, I know about him," said Dr. George.

"Well," said Dr. Cathell, "apparently he's made some sort of sexual assault on her. The health nurse found out about that. She also learned from the school nurse that the girl's IQ is about 70."

"Does her mother know about the assault?" Dr. George asked.

"I'm not sure. Of course, she has to be told so she can protect the child. I probably couldn't get anywhere with her, so I asked the health nurse to talk to her."

"How about the brother?"

"Well, that's another thing I want the health nurse to see about. She's not sure he's under proper medication. She thinks he's having one convulsion after another some days."

Then the discussion switched to another patient:

"You remember the woman with the chronic backache?" asked Dr. Heavrin.

Dr. Cathell laughed. "You mean the one who kept bending her back to show you how she couldn't bend her back?"

"She's the one. I can't tell her there's nothing physically wrong with her. She won't accept that. Now I'm finding it hard to get her to talk about anything except her physical symptoms. One thing I did find out: both her parents were in this clinic before they died, and she seems to feel that not enough was done here for her mother. She still feels some resentment about that, I think."

Dr. Cathell nodded. "I think you've learned something significant. If so,

she'll bring it up again. You only have to wait."

In the car again, Dr. Cathell said to me, "It's interesting to see what adept psychotherapists GPs can become. Not all, of course. Maybe one-third. And their brand of psychotherapy is different from psychiatrists'. GPs are more directive. They often know their patients better than psychiatrists know theirs, so transference occurs more quickly and strongly. Anyway, they don't have time to use the psychiatrist's techniques. Besides, I'm not sure these techniques are always best. Certainly the GP can accomplish much more his way than by trying our way. I can well understand that. I was a GP for 11 years before I became a psychiatrist."

Later, we visited the Public Health Office at Newland, where I learned something of Dr. Cathell's effort to make effective use of yet another community service. As part of the federal antipoverty program in Avery and Watauga counties, the Office of Economic Opportunity and Department of Labor have employed seven women, leaders in their communities, as "Friendly Home Visitors." Under the direction of Mrs. Celeste Brinkley, the "cracker-jack" health nurse, they visit mountain families and encourage them to take advantage of the services available to solve their health and economic problems.

Last December, Mr. Clayton Adams, health educator for the county under the antipoverty program, asked Dr. Cathell to speak to the Friendly Home Visitors about state mental health facilities. Dr. Cathell not only accepted but has also arranged to have several staff members from Broughton Hospital to do the same. "I'm trying to steal these women's time—to make mental health workers out of them."

In all he does, though, he is care-

ful not to overstep his bounds as consultant. "Sometimes psychiatrists speak of organizing GP's for community mental health," laughed Dr. Cathell. "Nobody organizes GP's. They are too independent, too autocratic; that's what makes them such effective doctors."

"In each county I entered, I spoke to the medical society. I told them I'd been assigned to a new project and asked for their cooperation. I usually told them I didn't know whether I could help them or not. That way, the pressure to get quick results was off. When we do get them, the GP is more likely to become a wholehearted supporter. It often takes only one success. I remember one physician who became an ardent ally because I advised him to give high doses of a tranquilizer to his father who had heart disease. Arrhythmias

so frightened the old man he'd become uncontrollable. Well, the tranquilizer worked, the doctor and his family got their first rest in days, and the next time I visited that town every physician knew the story and wanted to become part of the pilot project."

Dr. Cathell believes he has now learned enough to justify expanding the project; he has obtained an NIMH grant that will enable him to hire two part-time psychiatrists to serve other parts of the state. He also believes the success of the project could be duplicated anywhere—with the possible exception of the largest cities. But he adds, "The consultant has to be flexible. He should be alert to ways—even unconventional ways—to use the social services the community offers."

Daniel L. Cheney



Water Association Officers

The North Carolina section of the American Water Works Association and the N. C. Water Pollution Control Association elected new officers at the joint convention at the Jack Tar Hotel in November. These officers were installed as the convention adjourned: left to right, Chairman Col. R. F. Hill of Asheville, past Chairman Earle C. Hubbard of Raleigh, Vice Chairman Frank L. Ward of High Point, Secretary-Treasurer Max D. Saunders of Chapel Hill, Trustee Robert L. Carlson of Charlotte, AWWA Director J. M. Jarrett of Raleigh, and Trustee David Tobin of Charlotte. — Staff photo, Jim Sparks, Durham Herald-Sun.

Key Personnel Appointed for Reorganized Public Health Service

Surgeon General William H. Stewart has announced the appointment of a number of key personnel in the reorganization of the Public Health Service which is scheduled to go into effect on January 1.

At the same time, Dr. Stewart made public the names of appointees to staff positions in his own office in order to strengthen and intensify the work of the Service in advancing the health interests of the Nation.

In the Immediate Office of the Surgeon General, Dr. Leo J. Gehrig will continue as Deputy Surgeon General. Dr. Eugene H. Guthrie has been named Associate Surgeon General, third in line of command. Mr. M. Allen Pond will be Assistant Surgeon General for Special Projects; Dr. James M. Watt, Special Assistant for Program Review; Mr. John H. Kelso, Executive Officer and Director of the Office of Administrative Management; Dr. William L. Kissick, Director of the Office of Program Planning and Evaluation; Dr. Ernest M. Allen, Director of the Office of Extramural Programs; Dr. Charles L. Williams, Jr., Director of the Office of International Health; Mr. J. Stewart Hunter, Assistant to the Surgeon General and Director of the Office of Information; Dr. James H. Cavanaugh, Director of the Office of Comprehensive Health Planning and Development, and Mr. Robert M. Nash, Director of the Office of Equal Health Opportunity.

Chief Professional Officers are: Dr. Francis A. Arnold, Chief Dental Officer, Miss Margaret McLaughlin, Chief Nurse Officer, Mr. Albert H. Stevenson, Chief Sanitary Engineering Officer.

Names and titles of directors and deputy directors of the new Bureaus established by the reorganization follow:

Bureau of Health Services: Director, Dr. Leonard D. Fenninger; Deputy Director, Dr. Joseph A. Gallagher.

Bureau of Disease Prevention and Environmental Control: Director, Dr. Richard A. Prindle; Deputy Director, Mr. Vernon G. MacKenzie; Associate Bureau Director, Dr. Alan W. Donaldson.

National Institute of Mental Health; Bureau Director, Dr. Stanley F. Yolles; Deputy Bureau Director, Dr. Bertram S. Brown.

The National Institutes of Health, one of the largest Bureaus of the Service, as well as the National Library of Medicine and the National Center for Health Statistics will continue without major change in leadership. The National Institutes of Health is directed by Dr. James A. Shannon; National Library of Medicine by Dr. Martin M. Cummings, and National Center for Health Statistics by Dr. Forrest E. Linder.

Within the Bureaus, the following appointments are announced:

Bureau of Health Services: Mr. Jerold M. Michael, Director, Office of Program Planning; Dr. James D. Wharton,

Director, Division of Community Health Services; Dr. Gordon S. Siegel, Director, Division of Federal Employees Occupational Health and Safety; Dr. Harold M. Graning, Director, Division of Hospital and Medical Facilities; Dr. John W. Cashman, Director, Division of Medical Care Administration; Dr. John J. Walsh, Director Division of Direct Health Services; Dr. Henry C. Huntley, Director, Division of Health Mobilization; Dr. Erwin S. Rabeau, Director, Division of Indian Health.

Bureau of Health Manpower: Dr. Viron L. Diefenbach, Director, Division of Dental Health; Miss Jessie M. Scott, Director, Division of Nursing.

Bureau of Disease Prevention and Environment Control: Dr. Donald R. Chadwick, Director, National Center for Chronic Disease Control; Dr. David J. Sencer, Director, National Communicable Disease Control Center; Dr. Jerome H. Svore, Director, National Center for Urban and Industrial Health; Mr. James G. Terrill, Jr., Director, National Center for Radiological Health.

Additional key personnel will be announced in the near future.

[REDACTED]

All Men Dream

All men dream: but not equally. Those who dream by night in the dusty recesses of their minds wake in the day to find that it was vanity; but the dreamers of the day are dangerous men, for they may act their dream with open eyes, to make it possible . . . T. E. Lawrence: Seven Pillars of Wisdom.

[REDACTED]

PUBLIC RELATIONS ADVISERS ESSENTIAL TO MANAGEMENT

Here's a comment on the value of public relations to an organization's management, made by Thomas J. Deegan, Jr., chairman of the Deegan Company and executive vice president of Interpublic, Inc. (N.Y.C.)—as reported in the November issue of the **Public Relations Journal**: " . . . The easiest way to pour dollars down the drain is to hire competent public relations counsel and then **fail** to listen to it. Public relations resources are management resources. Experts in the field are best used when they participate in the decision-making process. Today's executive must not only consider every decision in terms of its effects on people, but he must regard his public relations advisers as essential aides who perform a specialized staff function in management."

GUILFORD AWARDED CLINIC GRANT

Eleven new comprehensive health care projects serving children and youth in low-income areas have been awarded grants totaling more than \$11 million, the Children's Bureau, Welfare Administration, Department of Health, Education, and Welfare announced recently.

These new projects, awarded since July 1, bring the total to 25 being financed under the new program authorized by the 1965 Social Security Amendments. Grants now total more than \$25 million.

In Greensboro, North Carolina, \$750,152 was awarded in the new grants to Guilford County Health Department for outpatient and satellite clinic programs providing comprehensive health care for about 20,000 children from families with incomes under \$3,000 per year.

Demand Exceeds Supply of Films

At

Health

Department's

Library

By ROY RABON

The State Health Department's film library is swamped by more requests than it can fill.

Roger G. Whitley, library supervisor, says the library has to turn down an average of 500 requests each month because there are not enough films in stock to meet the demand.

The library loans films to a wide variety of groups and clubs, but the majority of the loans are made to the public schools, Whitley said.

The library was budgeted \$30,150 this year with which to buy new films, replace worn out films and for repairs to films.

Whitley said the money is being used to buy additional copies of films already in stock instead of new titles to meet the demand for certain films.

"We're like the grocery store," he said. "We have some dead stock, and some films are in demand more than others."

Whitley said that he tries to stretch the budget "as far as possible" by buying black and white films except when color films are necessary. Color films cost about twice as much as black and white films.

"Films that demand color, such as films on the heart and circulation, have to be in color to get the point across," he said. "The others we always buy in black and white."

The number of films distributed by the library has increased 234.02 per cent in the last ten years; from 1,319 to 3,350.

The library distributes about 4,500 films each month, the largest number distributed by any State health department in the nation.

Although the library has 3,350 films—about 2.7 million feet—many of the films are duplicate copies. The library has 1,100 different titles.

Whitley said that the most popular film is "Narcotics: The Decision." Other films that are in demand include "Worth

Waiting For," a film about teen-age marriage; "Pulse of Life," a film illustrating mouth-to-mouth resuscitation and external cardiac massage; and "A Quarter Million Teenagers on VD," a documentary film on venereal disease among teen-agers.

Donated By Companies

Several large companies have given films to the library. "Without these free films our budget wouldn't be nearly enough," he said.

One large manufacturer of baby products gave the library 12 copies of a film on first aid. Each copy of the film normally would cost \$250.

The library has four machines which inspect and clean the films before they are mailed out; and about 4.6 million feet of film is processed by the machines each month.

Whitley said the library's biggest problem is caused by film borrowers who fail to return films on time. Because the films are in demand, requests are booked ahead of time and when someone fails to return a film other people have to wait.

Whitley feels the library plays a big role in the State, and has numerous letters from people who have borrowed the films.

Dr. John R. Ashe of Duke University wrote, "Thank you again for your excellent cooperation. These films have played a major role in our prenatal educational program and we could not continue without them."

And a letter from Mrs. Dave Roberts, assistant home extension agent in Pittsboro, said: "We wish to thank you so much for the film, 'Help Wanted.' It covered thoroughly all the things we wanted to stress at the training meetings and it taught them so much better than we ever could have."

—News and Observer, Raleigh, Nov. 11, 1966.

REHABILITATION ACCREDITATION

The new Commission on Accreditation of Rehabilitation Facilities (CARF) has contracted with the Joint Commission on the Accreditation of Hospitals (JCAH) to administer its program. Announcement was made today, December 16, 1966 of the newly signed contract by Howard G. Lytle, L.H.D., Executive Secretary of Goodwill Industries of Indianapolis, Chairman of CARF and Dr. John D. Porterfield, Director of JCAH.

Under the agreement, Dr. Porterfield will serve as Director of CARF. Trustees of CARF will establish standards for accreditation and will proceed with their previously announced purposes of awarding or withholding the accreditation of applying facilities, on the basis of field surveys and recommendations from its staff. It will select the surveyors who will examine the qualifications of sheltered workshops and rehabilitation centers seeking accreditation. In addition, the trustees of CARF will continue to approve appointments to its executive staff.

JCAH will provide executive direction, program planning, development and operational services and will house the CARF operation and supply office services necessary for the functioning of the Commission and its staff.

Charles E. Caniff has been appointed an assistant director of JCAH to facilitate the execution of the agreement and direct the Commission's activities. Mr. Caniff was formerly executive director of the Association of Rehabilitation Centers.

The accreditation program is expected to get underway early in 1967 when CARF standards for accreditation are published, surveyors are chosen and applications are made available to applying facilities.

Too Young to Die

Accidents are the greatest single threat to life for children at ages 1-4, killing about 5,000 preschool children each year in the United States. Accidents cause 1 out of 3 deaths among boys and almost as many girls. Since 1950, the rate of decline in accident mortality among children was less than half that of all other causes combined. The accident death rate for the period 1950-64 for 1 to 4-year-old boys dropped about 16% contrasted with 37% reduction for all other causes. Among girls, the accident death rate fell about 14% compared with 37% for all other causes. There has been no appreciable improvement in the accident death rate at the childhood ages since the trend leveled off about 10 years ago. Moreover the disparity in the rates between boys and girls remains unchanged; the rate among boys continues to be about a third higher. For all other causes of death combined, the death rate among boys is about a seventh higher than that among girls, a ratio which has also remained unchanged.

Motor vehicle fatalities, which numbered about 1,600 each year, dominated the accident mortality of preschool boys and girls. They accounted for a little over 30% of accidental deaths at ages 1-4. The pedestrian death rate in street traffic was especially high among the older preschool children, particularly the boys who are relatively more impulsive and active in their play. On the other hand, 1-year-olds of both sexes accounted for at least half of the 300 fatalities among preschool children who lose their lives in nontraffic motor vehicle accidents—those which occur in private driveways and yards, home garages, and similar places.

Fires and explosions were second in rank as a cause of fatal accidental death among preschoolers. The rate was slightly lower for girls than boys at ages 1 and 2, but somewhat higher at ages 3 and 4. Burns and scalds from hot liquids, steam, and other hot substances added more than 100 deaths to the annual loss of life among preschool children, predominantly among those 1 and 2 years of age.

Drowning was another major type of fatal accident among preschool children claiming over 700 lives each year. The hazard was particularly great among boys in the early preschool years; in 1962-63 about 42% of all drownings at ages 1-4 occurred among 1 and 2-year-old boys. Boys appear to show a marked susceptibility to drowning. Their drowning rate was 1½ times that among girls at age 1, a ratio rising to nearly 4 to 1 at age 4. Only motor vehicle accidents took more lives than drowning among 2-year-old boys.

About half of all preschool deaths from poisoning by solids and liquids occurred among 1-year-olds. In 1962-63, the death rate at age 1 averaged 4.9 per 100,000 among boys and 4.2 among girls—higher than at any other age.

An additional 5% of the accidental death toll at ages 1-4 during 1962-63 was attributed to falls—largely from windows and fire escapes, down stairs and out of beds.

Most of these accidents were preventable. Their prominence as a cause of death among preschool children and their large toll of disability underscore the need to intensify safety activities at this period of life.

Statistical Bulletin
Metropolitan Life Insurance
Company
August, 1966

Laws to Require Seat Belt Wearing May Be Proposed

Laws requiring drivers to wear their seat belts may be recommended by the National Safety Council. Its Special Committee on Seat Belt Usage recently said it is considering recommending such legislation to state officials.

"Universal use of seat belts could save the lives of more than 12,000 a year, according to the latest study available," said M. R. Darlington, Jr., Washington, D. C., the committee's chairman.

"Legislators, of course, will be cautious about accepting such a recommendation," Darlington added. "They will probably want answers to questions of the same kind we faced. But we have started to believe those questions may be less important than we thought."

"The resistance to wearing belts forces us to consider such a law," he said. "But it also is the source of the main reservations about recommending one."

The committee had faced suggestions that popular resistance is so strong it wouldn't be possible to enforce a seat-belt law. "On the contrary," Darlington said, "law enforcement experts tell us that under proper conditions, a law like this is almost self-enforcing."

"They say," Darlington explained, "that, first, if a law is drawn in what people consider a reasonable way and, second, if they are given plenty of time to get familiar with it before 'hard' enforcement begins, 70 to 75 per cent of the people will obey it automatically."

Further, he noted several recent liability suits in which the chance to recover damages had been lost because the accident victim had a belt available, but had not been wearing it. "The courts have suggested in a few cases that the state legislation that calls for belts to be installed must also have intended to require their use, and that non-use therefore constituted contributory negligence," he explained. Legislation like that being considered by the Safety Council committee would reinforce this judicial tendency, Darlington pointed out.

Thirty-three states and the District of Columbia now require the installation of seat belts in the front seats of new cars, the Council said. (Only New York requires seat belts in the rear seat, although they have been included as standard equipment in all new cars starting with 1966 models.)

The District of Columbia, Darlington said, already is considering legislation that would require the use of belts, and one municipality in Ohio has passed such an ordinance.

AMERICANS AVERAGE \$21 ANNUALLY FOR MEDICINE

Americans spent an average of \$21 for medicines in a 1-year period, according to statistics just released by the Public Health Service's National Center for Health Statistics.

These and other statistics on the costs and acquisition of prescribed and nonprescribed medicines were obtained for the year ending in June 1965 from a nationwide sampling of household interviews. Approximately 42,000 households were visited, comprising about 134,000 persons.

Of the \$21 total average expense, an estimated \$15.40 was spent for medications prescribed by physicians. These were defined as medications obtained on a physician's written prescription, including refills; medicines prepared on the basis of a physician's telephone call to a pharmacist; and medicines given by a physician or his assistant to a patient to take home.

The remaining \$5.60 was spent for non prescribed medicines including tonics, pills, salves, ointments, vitamins and first-aid supplies. Other medicines and drug sundries were listed in the survey as nonprescribed medicines.

The study revealed that the cost per person for prescribed medicines increased steadily with age from \$6.40 per year for persons under age 15 to \$41.40 for persons 65 years and over. The average annual expenditure for nonprescribed medicines rose from \$4 for persons under 15 years to \$8.80 for those 65 and over.

Women spent more for prescribed medicines than did men, according to the study. The average expenditure for women was \$18.60, compared to \$12 for men. The difference in expenditures between men and women for nonprescribed medicines was slight.

White persons spent an average of \$16.40 for prescribed medicines and \$5.80 for nonprescribed medicines during the 1-year period, compared to \$7.80 and \$4.20, respectively, for non-white persons, the study indicated.

The average cost of prescribed medicines increased steadily with rising family incomes, after the difference in age distributions of income groups was considered. There was a slight increase in expenditures for nonprescribed medicines with rising income levels.

Increasing educational levels resulted in rising average expenditures for medicines when the material was ad-

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justed for differences in age distributions of the various groups.

Residents of metropolitan areas had greater expenses for medicines than did farm residents in rural areas. Expenditures per person for medicines were higher in the South and West than in the Northeastern and North Central sections of the nation.

During the interview year, an estimated 879.8 million prescriptions for medicines were purchased at an average of 4.7 acquisitions per person in the population. The average cost per purchase was \$3.60. The term "acquisition" refers to the initial prescription as well as to later refills of the prescription.

An estimated 65.3 percent of the total costs of nonprescribed medicines was spent in drug stores and 20.1 percent in grocery stores. The remaining 14.6 percent was spent in such places as department stores and mail-order houses.

Cleft Palates - Research and Treatment

Over a quarter of a million persons in the United States have some form of mouth cleft. This year over 6,000 newborn babies will be added to that figure.

A new booklet, prepared by the National Institute of Dental Research, describes cleft lip and cleft palate and the research on its causes and various forms of treatment.

The publication explains that the oral cleft is one of the most common of all birth defects. It occurs when the structures which form the roof of the mouth fail to meet and grow together. The cleft may affect the whole palate or only a portion. The lip can be involved

along with the palate or by itself.

If not corrected, the cleft can cause hearing and speech problems, as well as affect breathing, swallowing, and chewing. However, studies show that, with adequate treatment and guidance, the cleft palate child can overcome these difficulties.

A cleft lip must be corrected by surgery. The palate may be repaired by surgery or covered by a "speech aid," which resembles a denture with an added extension on the back edge.

Before the cleft is corrected, the child develops different uses of the throat and mouth in speech, so that even after the cleft has been repaired, his speech may continue to sound strange. Often, speech training prescribed by a therapist can be carried out at home by the parents. In some cases, the child may need the direct supervision of a trained therapist.

Extensive research on the treatment, as well as the causes, of cleft palate is supported by the National Institute of Dental Research. Although heredity and environment appear to play a definite part in oral clefts, scientists thus far have been unable to pinpoint a specific cause. Most investigators suspect that the causes are complex and interrelated.

However, cleft palate specialists are quick to point out that parents should not blame themselves for the defect. With understanding and proper professional help, the cleft palate child can develop as any normal child into a useful, well-adjusted person.

Single copies of "Research Explores Cleft Palate," (PHS Publication No. 1487) can be obtained without charge from the Public Health Service, Washington, D. C. 20201. The pamphlet may be purchased in quantity from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402, for 10 cents a copy or \$6.75 per hundred copies.

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DATES AND EVENTS

February, 1967

February 5-11—DENTAL HEALTH WEEK

February 8-10 — American Academy of Occupational Medicine, San Francisco, California

February 8 — North Carolina General Assembly Convenes

February 9-15 — Congress on Medical Education, American Medical Association, Chicago, Ill.

February 10 — N. C. Mental Health Council, Raleigh, N. C.

February 15-19 — American College of Cardiology, Washington, D. C.

February 21-23 — Biophysical Society, Houston, Texas

February 23-25 — Central Surgical Association, Pittsburgh Pa.

February 28 — National Multiple Sclerosis Society, New York

February 26 - March 2 — International Anesthesia Research Society, Bal Harbour, Fla.

February 27 - March 3 — American College of Physicians, N. Y. University Medical Center, New York

March, 1967

4-11 — Canadian-American Medical & Dental Association, Vail, Colo.

5-9 — 16th Annual Meeting of the Na-

tional Council on the Aging, Hotel Plaza, New York

5-9 — International Anesthesia Research Society, Bal Harbour, Fla.

9 — N. C. Conference on World Affairs, Memorial Hall, UNC, Chapel Hill

9-10 — N. C. Mental Health Association (Annual meeting) Hotel Sir Walter, Raleigh

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